REPORT OF THE MONTANA MENTAL DISABILITIES BOARD OF VISITORS ON WARM SPRINGS STATE HOSPITAL

STATE OF MONTANA
Office of the Governor
Mental Disabilities Board of Visitors
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Thomas L. Judge
Governor

In accordance with The Mental Commitment and Treatment Act of 1975, Title 38, Chapter 13 of the Revised Codes of Montana, 1947, the Mental Disabilities Board of Visitors issues this report on Warm Springs State Hospital. Conducting this site visit were Board members: Al Bertelsen, Patricia Boedecker, Virginia Kenyon, Dr. Jack Stimpfling, and Dr. Fran Rummel; staff member, Kelly Moorse; along with in-state consultants: Dr. William Docktor, Clinical Pharmacist, Missoula, Montana; Dr. Frank Seitz, Clinical Psychologist, Bozeman, Montana and Dr. Jan Wollersheim, Clinical Psychologist, Missoula, Montana.

The Board's report is based on a three day site visit, involving interviews with the staff and the following administration: Dr. E. P. Higgins, Acting Superintendent; Mr. Richard Moore, Hospital Administrator, and Mrs. Jane Edwards, Director of Nursing. In addition to reviewing the physical facilities (38-1330 (4) R.C.M., 1947), a random sampling of patient files were examined for treatment plans. (38-1328 and 381330 (5) R.C.M., 1947).

After this report is presented to the acting superintendent of Warm Springs State Hospital, it shall be made part of the annual report of the Board of Visitors to the Honorable Governor of the State of Montana.

BOARD OF VISITORS REVIEW OF

Warm Springs State Hospital

April 26-28, 1978

ADMINISTRATION

Just prior to the Board's site visit, new reorganization plans for Warm Springs State Hospital were announced. In place of the regional system, the hospital is establishing an In-take unit, Short-term unit, Long-term unit and Pre-release unit. The Forensic, Children and Geriatrics will remain as before. According to the administration, the purpose of this reorganization is to offer greater accountability and more effective utilization of resources.

The implementation of this reorganization includes the addition of a Quality Assurance Department. This department, to be headed by the former director of Nursing will be responsible for in-service training, program evaluation, policy development, nursing coordination, and technical assistance. (See Appendix A, page three.) The treatment area will be directed by a unit supervisor, who will be accountable to the Manager of Psychiatric services (a new position) and/or the Director of Treatment (also a new position). The administrative flow chart is on page four of Appendix A.

Under the new proposal the acute medical and surgical unit will be moved to Galen State Hospital. This move, which would involve an average of ten to fifteen patients plus the future possibility of transferring the Geriatrics

population to Galen, raises concerns regarding the continued expense of maintaining the facility at Galen. Galen State Hospital is not equipped, nor staffed to handle psychiatric patients. The shuffling of these patients and the overall effects on these persons raises additional concerns, especially at a time when there may be some question about the continuation of Galen being justified to the taxpayers.

The Board of Visitors was assured by the administration that no reduction in staff would occur at Warm Springs State Hospital as a result of this reorganization. During the site visit, the Board and its consultants were subject to a great deal of communication both for and against this new proposal. A large part of staff concerns were related to anxiety over lowering the level of patient services and individual job security, since all positions were up for bid in this new process. Obviously such employee stress can be deterimental to overall patient care, unless the administration takes strides in communicating all aspects and ramifications of the reorganization process. Hopefully the overall results of reorganization at Warm Springs State Hospital will mean increased patient care and treatment.

FORENSIC UNIT

Maximum Security: #56 and #57

The patient census at the time of the site visit included seventeen men in Maximum Security and eight men in Medium Security. No patients were under the age of eighteen. According to Head Nurse, Mrs. Beverly Beck, only two patients under the age of eighteen have been admitted to

this unit in the last six months.

In reviewing this facility, Dr. Frank Seitz stated that current staff-patient ratios were unacceptable. Only one Registered Nurse was on duty during the day to provide medical coverage for two widely separated buildings (#56-#57 and #85-#86). Only two LPNs were also responsible for both units. The number of Special Duty Attendants varied between four and six aides for the Maximum Security unit. Given the limited number of staff and given the established security ratio of four patients to one staff person, patients were severely restricted in terms of physical activity. For example, patients are able to be supervised by staff in the exercise yard only an average number of three times a week. Aside from once a week Arts and Crafts session and once a week Discussion session, no other scheduled activities take the patients from their locked rooms and/or ward. Therefore, the vast number of patient hours are spent pacing in a narrow hallway, being unable to see outside except for a heavily screened window in their cell, and looking at the cheerfully painted doors and bars of the cell block.

Aside from admitting prison inmates (who remain under the jurisdiction of the Prison Warden), and violent/suicidal patients from other regions of the State Hospital, the Forensic Unit evaluates patients for the Court Systems. These evaluations generally consist of medical workups, including blood chemistries, urinalysis, chest and skull x-rays, and EEG monitorings. When indicated, neurological exams are conducted. The psychological component of the

evaluation technically includes a psychiatric mental status examination, a social history, and formal psychological testing. A Diagnostic Clinic is then convened and a summary of findings is sent to the Court.

In the random file review by Dr. Seitz, some deficiencies were found in diagnostic information. In one case (#4-36779), the present diagnosis of Paranoid Schizophrenia and the most current treatment plan did not indicate the extensive history of drug and alcohol abuse which was buried in a morass of difficult to read progress/staff notes. The second case (#4-31729) contained two different diagnoses, one from the psychological examination and one from the mental status exam, with both diagnoses made by the same staff person on the same day. Further, these inconsistencies, according to Dr. Seitz, proved difficult to resolve because of a lack of useful descriptive information about the symptoms and the behavior of the patient. Psychological test jargon tended to obscure the meaningfulness of the report. Psychological conclusions appeared based more on the intuitive "feel" of the examiner for the patient than on readily defined, objective data. The validity of such intuitive, subjective impressions as evidence in Court is clearly questionable, at least from a psychological viewpoint.

However, since the Board's last site visit to this region on August 25, 1977, there were noted improvements in the physical facilities; namely the recent interior painting and the repaired roof.

Minimum Security #85 and #86

Two days prior to the Board site visit the twenty-seven patients residing in Musigbrod were transferred to Unit #85 and #86 (formerly the Children's Unit). The new environment, an improvement over Musigbrod, offers semi-private rooms and two four bed wards. In addition the day halls are bright and cheerful.

However, as stated before only one R.N., shared between Maximum and Minimum Security, is on duty during the day. The number of Security Duty Aids, according to LPN Scalise, is always three men and usually three women. The Board observed the Nursing and Aid notes were up-to-date and in good condition. With the new facilities, the patients are now offered Occupational Therapy four to five times per week, in comparison to two days a week at Musigbrod. In addition, there are plans to use the lower level of this building as an activity area where independent living skills and additional self help skills will be taught. The Board commends this unit's staff in their pride and dedication in offering additional services to the patients.

CHILDREN'S UNIT

The present facility used to house the Children's Unit is much improved from the prior quarters. While the building is somewhat old, it is roomy and offers more materials and equipment, enabling the patients to have good access to a diversity of activities. Although the building affords more space for activity, there is less privacy offered to these young people. In contrast with the three to four bed

wards of the old unit, there are now only two large wards; one for the boys and one for the girls.

Overall, the facilities were well kept and tidy. The Board's consultant, Dr. Jan Wollersheim, noted two minor criticisms in this regard. The pre-vocational area was untidy with materials scattered about and not in proper storage areas. The same can be said of the kitchen. While untidiness does occur, even under the most orderly of circumstances, the consultant and the Board members had the impression that this situation needed improvement.

The average number of residents in the children's program is twenty-three. The staff-to-patient ratio in the children's unit appears to be excellent during the day. There is still inadequate staff to offer sufficient evening and weekend activity for these young people. Presently, there is only one psychologist on the staff, but the unit director explained that he has received permission to hire a second psychologist. There are two social workers for the staff, in addition to the unit director, who is also a social worker. Three nurses are associated with the program, as well as two licensed practical nurses and a number of psychiatric aides. In addition, the children have the services of school teachers, a vocational teacher, and one or more rehabilitation therapists. In observing the children's unit, the Board's consultant stated there seemed to be adequate staff for supervision and the implementation of treatment programs.

In the course of the consultant's conversations with the director of the program, another staffing issue was re-

viewed. The present staff psychologist in the Children's Unit is a licensed psychologist in the State of Montana, but his speciality area is that of developmental psychology (which is an area in experimental psychology) rather than clinical psychology, which is the practitioner area involved in patient assessment and treatment. The problem, according to Dr. Wollersheim, is that since this psychologist is a licensed psychologist, but with a speciality area in an experimental area, rather than a clinical area, he has an ethical problem in that psychologists who are licensed are supposed to adhere to the code of ethics of the American Psychological Association. It should be made clear here that the issue is not whether the psychologist is competent, nor whether he should have employment in the children's unit. All evidence points to the view that this psychologist is competent and manifests a considerable amount of psychological knowledge and skill. Nonetheless, the psychologist on the Children's Unit has a problem with his own profession since he is a licensed psychologist. See Appendix F for further information.

In general, the diagnostic and assessment workups of the children appear to be thorough and comprehensive. The consulting psychologist paid particular attention to psychological reports and these reports met generally acceptable professional standards. The psychological reports are characterized by the administration of a considerable number of assessment instruments. According to Dr. Wollersheim, more emphasis could be placed upon drawing out the interpretations of test data and specifying implications

for the treatment of the child. While not a necessity, psychological reports could be improved by more evaluation in the area of personality, including not only personality tests as such, but clinical assessment interviewing and integration of these findings with other test data in delineating overall implications for treatment.

The reports entitled "Psychiatric Evaluation" were found to be thorough and comprehensive. In the sample of these reports read by the consultant, it was noted that, although the reports were labeled "Psychiatric Evaluation", they were actually conducted by the director of the unit who is a certified social worker. These reports were signed by one of the hospital psychiatrists, who served as a supervisor of the psychiatric evaluation and the written report. The consultant discussed this issue with the director who had written the reports. While the reports are good, and while there does not appear to be an ethical problem with having a psychiatric report written by a social worker under the direct supervision of a psychiatrist, the procedure is somewhat misleading since one would ordinarily expect the psychiatric report to be written by the psychiatrist. The unit director explained that the psychiatrist had too heavy a case load to assume this responsibility. Additionally, Montana law provides that certified mental health professionals may conduct the examination of patients. Dr. Wollersheim stated that the children's unit may want to consider relabeling such a report with a title such as "Mental Examination". Such a label is then not misleading since a number of mental

health professionals are authorized to make such evaluations by Montana statutes. When a report, however, is labeled "Psychiatric Evaluation", it is reasonable to expect that both the evaluation and the write-up of the results will have been performed by a psychiatrist. Since this does not seem to be the case in the children's unit, a more accurate labeling of the reports might be less misleading.

Overall, the treatment plans specified for the children on this unit are good. Staff are conscientious in describing both long-term and short-term goals. For the most part, goals are described in terms of specific behavioral objectives. The children receive many types of therapy including individual therapy, group therapy, recreational therapy, music therapy and others. Besides the usual types of therapies, they appear to have a very good pre-vocational program in which they can not only learn job related skills, but can develop certain behaviors such as taking responsibility, gathering information, working with others, and other characteristics that are necessary for holding almost any kind of employment. The children have available to them a kitchen and they become involved in preparing and serving meals to various groups at selected times. Such experiences not only give the children training in basic types of skills, but they also help them acquire many behaviors necessary for independent living.

A very positive feature concerning treatment plans and utilization was the creation of a real treatment milieu on the children's unit by the ward staff. Written treatment

plans specify particular problems and specify how ward personnel are to work together to help the child overcome these particular problems. In visiting this facility, the consultant found many instances where the ward staff followed sound treatment guidelines in responding to the normal, everyday activity of the youngsters.

Incorporated into the whole treatment program is the concept of patient self government, whereby children are allowed to participate in formulating policies and procedures and in implementing adherence to these rules. Such an experience had the potential of being maximally beneficial in teaching the patients to evaluate appropriate and inappropriate behavior, to realize what effect this behavior has on the individual and on others, and to explore reasonable methods for helping an individual overcome his behavioral problems. The staff are to be commended for the time, patience, and skill they have devoted in helping the patients implement their own government.

According to the unit staff, biofeedback training is used to a significant extent to help the children learn to relax and to reduce problems that are related to tensions. The unit director believes that biofeedback training has been beneficial in helping various children attain more normal sleep patterns. He explained that the staff psychologist is the resident expert on biofeedback training and that the psychologist is finding it helpful in aiding many of the youngsters who get into trouble because of their "acting out" behaviors. Apparently, the youngsters are helped to see that, just as they are able to learn to

control their temperature, muscle tensions, and other physiological responses, they can also learn to control and modulate their feelings and behaviors. Although the staff was very enthusiastic about the biofeedback training, the children's records reviewed by the Board of Visitors did not seem to evidence any documentation of their receiving this type of therapy in the official files.

With regard to treatment plans, it seems that the hospital staff are somewhat handicapped in making aftercare plans for the children since many of them will need an environment less structured than the hospital, but more structured than the type of environment found in the typical foster or group home. Such a situation, according to Dr. Wollersheim, does point to the need for state sponsored residences for emotionally disturbed children who have evidenced considerable improvement at Warm Springs State Hospital and who need an intermediate treatment facility before they can reenter the more typical type of community living.

Federal funds will no longer be supporting the children's unit after June of 1978. The unit director reported that the staff have made plans to insure the funding of the unit by exploring funding sources and writing additional grants. In reviewing the Community Mental Health programs of the state, there is evidence of monies and plans to service children within their own community. It would seem most appropriate that the children be treated within their local community, if the mental health centers are in fact funded to provide such services.

REGION II

The patient census in this unit has been reduced from one-hundred seventeen, in 1975, to a present figure of thirty-five. The staff, which was extremely enthusiastic about their treatment milieu, stated it was the only regional unit that has seen a systematic decrease in census and an increase in treatment experiences. They cited eight therapeutic activities for each resident per week as compared with 6.5 activities in Region I, 5.4 activities each in Region III and V, and an average of eleven for the Intensive Treatment Unit.

Region II employs a level system (open, intermediate, and closed) which has certain requirements determining where a patient will reside during treatment in this Region. Appendix B describes the three levels of activity.

The Board, in a random sampling of patient files observed that eight men and eight women had reviews and updates of their treatment plans done on the same day. Although this date was just prior to the Board's site visit, such an endeavor raises the question of the thoroughness of treatment planning. In addition, the file review revealed many of the charts were disorganized and not in chronological order, especially #2-15731 and #2-24612.

REGION III

Region III, which serves forty-six residents uses no formal level system. There is one open ward housing thirteen men and women. This self-governing ward is responsible for many independent skills, as well as patients' own housekeeping.

File documentation, implementation of treatment plans and progress notes were well kept. The staff appeared to be enthusiastic and dedicated in implementing the resident's treatment plans. The Board's consultant raised concern regarding one individual (#3-20029), whose file shows no diagnoses which should confine him to the institution. Additional comments regarding this unit can be found in the Medical Section of this report.

REGION IV

This unit consists of four wards, three of which are locked and one which is an open ward. All of these wards of the Bolton Building, are outdated, dilapidated and offer no pleasant environment. The dismal physical plant is depressing and inadequate as a therapeutic milieu. For example: the bathrooms open directly on the hall with minimal privacy; the toilets have shower curtains on some stalls; and the shower area has paint and plaster falling off the walls; and several garbage cans in the adjacent room which houses the master valve for three semi-private shower stalls.

Of greater concern, however, is the dangerously low staffing situation. The one locked ward had a census of twenty-five patients and only one aide. The open ward had twenty-one women and ten men patients with only one aide. If an emergency does occur, the lone staff person must phone for help from the Forensic Unit, which then must secure all its patients before a Security Duty Attendant can be sent across the hospital grounds to the Bolton Building. Such a

maneuver is far from efficient and can consume too much time.

It goes without saying that the scandalously pathetic staff/patient ratio allows little in the way of treatment, because of the demands of direct custodial care. Some occupational therapy and music are provided by various departments outside the unit.

A compounding problem involves the high admission rate to this unit which causes an overload of the psychiatrist's time and results in less time for patient treatment. As one staff person observed, "We treat paper instead of patients during most of our time". With such staff overloads, it is little wonder that treatment plans remain only on paper and that patient treatment in fact is patient warehousing in a decrepit building. The Board of Visitors remarks are not meant to criticize the staff of this Unit. The staff of Region IV obviously works hard, knows its patients and is doing the best it can within a very bad situation. There is simply not enough staff to meet all the needs of these residents.

In addition, the Head of Maintenance informed the Board of Visitors that the Hospital's budget contains no funding for capital expenditures for this year and next. This means no physical improvements for the Bolton Building for the next two years. The tragic fact of this matter is that the Bolton Building will be used for chronic patients when the new reorganization plan for the Hospital is implemented.

REGION V

This unit, presently housed in the Mitchell Building, which

is scheduled for demolition within the next several months, also employees a level system. The patient treatment program is structured according to four levels, each representing incremental sets of privileges. A copy of this system is found in Appendix C.

A random sampling of patient records on this unit revealed excellent diagnostic workups, current progress notes and nursing notes, and treatment plans that seemed sensible and realistic. For example, plans for a resthome patient diagnosed as an Organic Brain Syndrome with Crebral Arteriosclerosis were as follows: "Make patient as comfortable as possible while here. Encourage more exercise and provide opportunity for reality orientation." (#5-36830).

The present census of fifty-six patients places considerable pressure on psychiatric coverage such that physician progress notes vary from weekly to bi-weekly.

The staff on this unit indicated considerable concern about the Hospital reorganization plan. They stated that confusion and low morale have resulted in the piece-meal diffusion of information about the plan and staffing changes. It seems sad indeed that one of the few incentives for working at the State Hospital, that of staff cohesiveness and comradery, might be jeopardized by administrative re-shuffling of staff. Hopefully a minimum of <u>expirit de corp</u> within the staff will be eroded by the reorganization plan.

INTENSIVE TREATMENT UNIT

This unit, whose average census is seventeen patients, is staffed by a daytime group of nine mental health profes-

sionals. The focus of treatment is with the acutely schizophrenic.

In contrast to many of the units, this ward has a demanding activity/treatment schedule for its patients. In addition, patients are placed in a Level System which consists of four levels of privileges based on a patient's behavior on the ward. Discharge planning begins immediately, focusing on short term treatment goals which involve the patient and their family. A copy of this program is contained in Appendix D.

This unit contains a Time Out and Security Room, both of which had inoperative toilet plumbing and could use some cleaning. The Board of Visitors was assured that when a patient is in these rooms, he is checked every fifteen minutes.

The staff was clearly concerned with the Hospital reorganization plans and the status of the Intensive Treatment Unit. The Board supports this unit and its continuation at Warm Springs State Hospital.

MEDICATION

According to the Board's consultant, William Docktor, there was no indication of a history of medication summary included in the patient files inspected. This history of past medication is necessarily the basis for the present choice of medications. No previous history of adverse drug reactions was documented, which again is a major factor in choosing current medications. Among the sample of patient

files reviewed, only one drug allergy was documented and this documentation did not provide sufficient data. Only one half of the sample of patient records had documentation regarding allergies. The drug abuse history serves as an indication of the patient attitude toward drugs. In only two cases, where a drug overdose was used in an attempted suicide, was a semblance of drug abuse history present.

In most cases, the indications for each medication was apparent. In a few cases the consultant's choice of psychotropic agents would have differed from that of the prescriber (#2-15731, 2-32375, 3-23809, 3-26640). The use of vasodilators such as papaverine HCl or isoxuprine HCl in the treatment of Organic Brain Syndrome due to cerebral vascular insufficiency has little supporting evidence. Several patients on the geriatric unit were receiving vasodilators for this purpose (#5-36965, 5-29888, 5499). Unfortunately, this practice is prevalent in skilled nursing facilities nationwide.

The Board's consultant stated that relative contraindications to psychotropics (C24612, 3-20029, 2-25103, 5-36965, 3-34344, 5-29888, see Appendix E) were present, and in three cases the risk:benefit ratio is not justified (C24612, 3-20029, 5-29888). In addition, cases of drug toxicity (C35768 and 5-29888) could have been precluded with more rational drug therapy.

On one occasion (C24612) a severe drug reaction may have been avoided if a well-trained person (psychiatrist or other) had re-evaluated the patient before a second upward

increment in the dosage of haloperidol was instituted. Fluphenazine decanoate is an injectable preparation given intramuscularly. It has a duration of action such that injections are usually necessary only at three or four week intervals. In one case (3-23809), fluphenazine deconoate was being injected weekly. There is no apparent reason for the frequency of this injection, other than it may be easier to remember to administer a drug every week rather than every third week.

The prescriber for each patient was evident since all medications were rewritten by the nurse each month and countersigned by a physician. Only one case of multiple prescribers was found (30115). This is also the only case found where some orders were not signed.

The responsibility of review and follow-up is taken by the physician who countersigns the monthly orders. It is hard for the Board and its consultant to believe that an active review process is being carried out by these physicians. In one case (C24612) appropriate follow-up may have precluded a severe drug reaction and in another (2-32375) a delay in changing drug therapy may have been avoided. It appears that the doctors rely heavily on the nurses for follow-up on drug therapy. (This is not necessarily bad, especially if the competencies of the nurses are sufficient).

The Board's consultant stated that it appears that no one person is taking the time necessary to integrate all treatment modalities. In addition, no one is following up on drug therapy, either psychotropic or medical, so as to

optimize drug therapy. An excellent example is (3-36640), where drug review is needed, as the drug regimen is questionable and the diagnoses are explicit. Serious drug toxicity or reactions which could have been avoided, occurred in three instances and an unnecessary delay in changing medications occurred in a fourth case. In three cases contraindications were present which should have resulted in the choice of a different agent. Several patients were receiving drugs of questionable efficacy or drugs which are not the most appropriate. Some drug therapy regimens according to the consultant, were not completely rational and one even borders on the irrational.

MEDICAL RECORDS DEPARTMENT

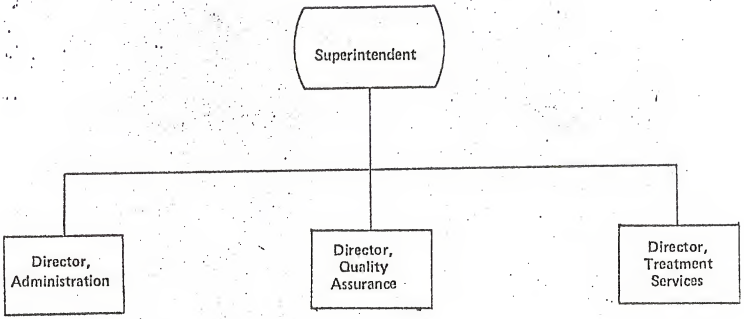
Continual corrections have been noted in this department by the Board of Visitors, and since the last site visit, additional improvements have been made. In the last sixteen months, over one-thousand deficient files have been updated. The department has hired a record clerk who monitors discharged persons files, flags deficiencies and then informs the responsible department/person of the information necessary to complete the file.

In-service training in medical terminology, plus a future course in Basic Medical Records Science, is being offered to ward clerks and others in the medical records department. The department head is attempting to get additional monies to help fund the staff in receiving accreditation as records technicians. Hopefully, such education will be provided to these individuals so that continual monitoring

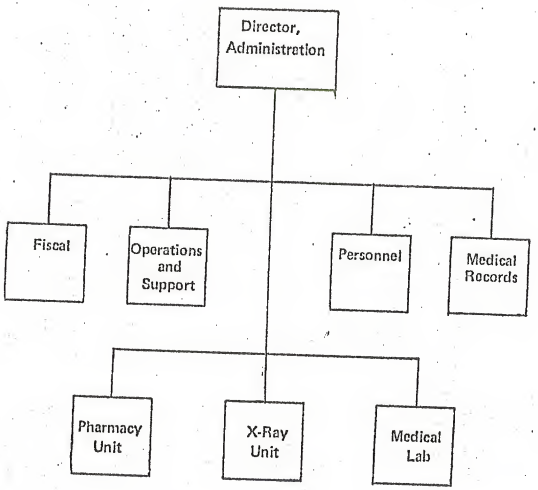
and improvements will be seen in the records system at Warm Springs State Hospital.

APPENDIX A

Organizational Chart



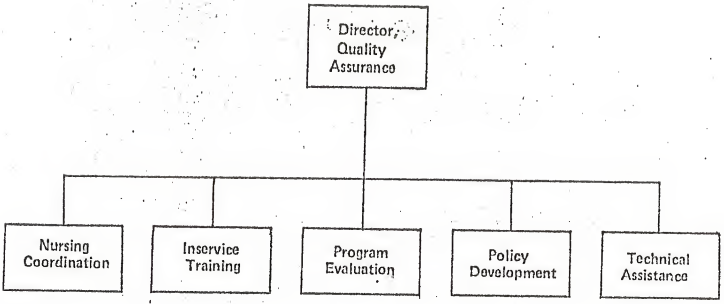
WARM SPRINGS STATE HOSPITAL



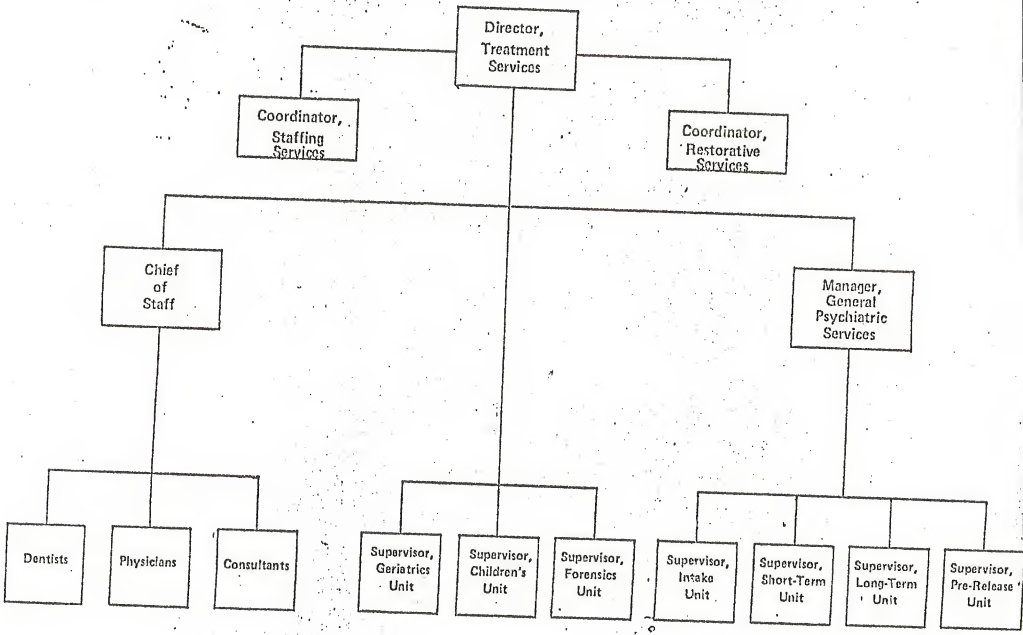
WARM SPRINGS STATE HOSPITAL

ORGANIZATION

ADMINISTRATION FUNCTIONS



WARM SPRINGS STATE HOSPITAL
ORGANIZATION
QUALITY ASSURANCE FUNCTIONS



WARM SPRINGS STATE HOSPITAL
ORGANIZATION
TREATMENT SERVICES

APPENDIX B

Region II Program

REGION II
PROVISIONAL GENERAL RULES

1) Patients admitted to Warm Springs State Hospital or transferred to Region II from another Warm Springs State Hospital Unit will begin their therapeutic experience from our closed ward.

2) All patients will be expected to progress from the closed ward, to the intermediate ward, and finish their therapeutic experience on the open ward. Progress will be based upon specific behavioral criteria.

3) Patients may participate in supervised activities in the building and can be allowed to go to the food center at the discretion of the treatment team before diagnostic clinic. This decision by the treatment team will be based upon 48 hours of observation by the treatment team.

4) All patients will attend regular patient-staff meetings on the ward to which they are assigned.

5) To insure that the Region II therapeutic community remains as positive an experience is possible for both patients and staff, abusive and/or threatening language will not be considered as an appropriate way to express angry feelings.

6) Threats of violence or violence will not be tolerated.

7) The use of alcohol and/or street drugs severely hampers a person's ability to function and makes the helping process more difficult to provide. Therefore, all patients of the Region II therapeutic community are to abstain from alcohol and/or street drugs.

8) Issues surrounding sexuality are often times frightening and damaging to patients in a therapeutic community. Therefore, patients of Region II therapeutic community are to abstain from sexual activity while patients of Region II.

9) Patients will participate in the development of his or her treatment plan.

10) Institutional safety standards require smoking be allowed only in designated areas. Region II patients are to abide by this rule for this rule for the safety of all people living and working on Region II.

11) All patients on all three Region II wards are asked to be out of the dorms with bed area clean by 7:00 A.M. on weekdays. The open and intermediate wards will be allowed to get up on weekends and late as 10:00 A.M. on weekends and holidays.

12) Structured activities will be developed by staff and/or patients every weekday evening. Patients on closed and intermediate wards will be required to attend.

CLOSED WARD BEHAVIORAL CRITERIA

POLICY: Staff members will assist patients assigned to the closed ward to perform the behaviors listed below. When the patient is capable, staff members will teach him/her to perform these behaviors so that movement to the intermediate ward is made possible.

Procedure: All closed ward patients will be required to follow the schedule listed below in addition to following the General Region II rules:

1) All closed ward patients will be supervised by night shift to perform the following behaviors:
   a. face and hand washing
   b. personal grooming
   c. teeth brushing
   d. put on appropriate clean clothes.

   Cigarettes will be distributed after these behaviors are completed by all closed ward patients and before said patients are escorted to the food center.

2) Those closed ward patients who take medications will return from the food center and take their morning medications at the designated area.

3) When morning medications are completed, closed ward patients will be required to clean-up their bed area and make their beds with staff supervision.

4) Patients who are assigned for baths on a specific day will immediately begin that activity after bedmaking. Patients not assigned to take baths on that day will immediately attend their therapeutic activities.

5) All patients on the closed ward will be required to participate in therapeutic activities daily from 8:30 A.M. until 3:00 P.M. if appropriate therapeutic activities are available.

6) Select patients will be required to participate in assinged therapeutic experiences during evening shift.

7) From 3:00 P.M. until 5:00 P.M. is designated as free time.

8) Closed ward patients will be escorted to their activities at staff discretion.

Promotion Requirements:
Follow the above described schedule with little supervision.

Be considered a potentially acceptable member of the intermediate ward by staff and patients.

Be willing to abide by the rules of the intermediate ward.

Privileges allowed:
Supervised activities in the building.

Cigarettes contingent upon following the above described schedule.

Participation in supervised activities off of the building at staff discretion.

INTERMEDIATE WARD BEHAVIORAL CRITERIA

POLICY: Staff members will supervise patients assigned to the intermediate ward in performing those behaviors learned on the closed ward. In addition, the following list of expectations will be required of intermediate ward patients.

Procedure: All intermediate ward patients will be responsible to participate in developing of an individualized treatment package with the treatment team.

1) Each intermediate ward patient will be responsible for developing, presenting to the treatment team and implementing three (3) therapeutic activities to replace those required on the closed ward.

2) Intermediate ward patients will be responsible for the care of their own laundry.

3) Intermediate ward patients will be responsible for getting to and from their therapy assignments without escort. They will also be responsible to get medications, and be at ward functions with minimal supervision.

4) Intermediate ward patients will be required to complete a ward chore routinely to develop a sense or community responsiblity.

Promotion Requirements:
Maintain learned behaviors from closed ward experience.

Fulfill therapeutic activities contract.

Function as a contributing member of the intermediate ward community.

Be evaluated as a potentially acceptable member of the open ward by both staff and patients.

Privileges Allowed:
Ground passes to work and school activities.

Supervised activities off the building and off the grounds at staff discretion.

Up to 3 hours ground parole.

OPEN WARD BEHAVIORAL CRITERIA

POLICY: Staff will assist the open ward patient in working through her/his interpersonal, institutional, open ward community, and discharge related difficulties. Open ward patients will require negligible supervision and be responsible to participate in treatment team approved assignments, attend required functions, and monitor their own behavior.

Procedure: All open ward patients will be required to attend their assigned therapeutic experiences, facilitate the development of a sense of community by responsible others-helping behavior.

1) Open ward patients will be required to respect the rights of others to privacy by staying out of other patients rooms, and by not handling others personal belongings.

2) Visitors will be allowed on the open ward with a permit only. All visiting of open ward patients will be done in the designated lounge. No visiting will be allowed in patient's rooms. Visitor's room is for use with visitors only.

3) Each patient on an open ward will be responsible to have and care for personal items such as cigarettes.

4) The East wing of the open ward is off limits.

5) Open ward patients are responsible for getting own meds, attendance at therapeutic assignments, keeping dorm room clean, grooming and clean clothing as well as regular bathing without supervision.

6) No food will be allowed in the rooms.

7) Open ward patients will be responsible to maintain the dorm area, the day hall, and bathrooms with special emphasis on cleaning up after oneself.

Promotion Requirements:
Develop an adequate discharge plan with the social worker which is approved by the treatment team.

Fulfill the above described expectations.

Privileges Allowed:
Full ground parole.

Releases to the community for business matters as approved by the treatment team.

Access to the dorm area during the daytime.

Participation in the development of the rules governing the open ward community.

WARM SPRINGS STATE HOSPITAL
WARM SPRINGS, MONTANA

PROGRAM DESCRIPTION

Discussion Group Therapy - Region II - Monday, Wednesday & Friday, 3:00 to 4:30

This is a discussion therapy group for residents of Region II, on the above days held in the conference room on Region II. This group is limited to nine members. All residents are eligible for evaluation, to be included in this group. Acceptance is based on:

1. Availability of a vacancy
2. The resident's ability to benefit from a discussion group therapy situation, based on, but not limited to the following:
    a. a near average intelligence quotient
    b. near average verbal skills
    c. near average cognitive skills
    d. a lack of overt psychotic symptoms

Common group goals include, but are not limited to:

1. Increased socialization skills
2. Increased communication skills
3. Decreased delusional thinking
4. Increased self-awareness
5. Increased problem-solving skills

Individual objectives may include increasing spontaneous verbalizations to peers, increasing appropriate eye contact during communication; decreasing inappropriate verbal interruptions; decreasing inappropriate subject of discussion changes; decreasing expressions of delusional nature, identification of problems and ways to deal with them. Appropriate identification of internal affect and methods of appropriate expressions are stressed in the group situation.

Those group goals and individual objectives may be dealt with through conventional psychotherapeutic techniques, including Gestalt, Reality Therapy, Transactional Analysis, Role Playing, or any combination thereof.

Steve Stauber, RMT

Steve Stauber RMT

SS/bz
tr: 3/2/78

WARM SPRINGS STATE HOSPITAL
WARM SPRINGS, MONTANA
PROGRAM DESCRIPTION

DISCUSSION GROUP THERAPY - Region II, Tuesday and Thursday, 3:00 to 4:00

This is a Discussion Therapy Group for residents of Region II, on the above days, held in the conference room on Region II. This Group is limited to six members. All residents are eligible for evaluation to be included in this Group. Acceptance is based on :

1) Availability of a vacancy.

2) The residents ability to benefit from a Discussion Group Therapy situation based on, but not limited to, the following:
   a) Less than average verbal skills.
   b) Less than average cognitive skills.
   c) The presence of overt psychotic symptoms.

Common Group goals include, but are not limited to:

1) Increased socialization skills.

2) Increased communications skills.

3) Decreased delusional thinking.

4) Increased environmental awareness.

5) Increased Group tolerance.

6) Advancement to Monday, Wednesday and Friday Group.

Individual Objectives may include:

1) Increasing appropriate verbalizations on request and spontaneously.

2) Decreasing delusional expression.

3) Increasing communication with peers.

4) Increasing the amount of time tolerated in the Group situation.

5) Increasing appropriate emotional expression.

These Group goals and individual objectives may be dealt with through conventional psychotherapeutic techniques, including Gestalt Reality Therapy, Role Playing or any combination thereof.

Steve Stauber, RMT

SS/ph

1/2810/5
3/3/78

WARM SPRINGS STATE HOSPITAL
WARM SPRINGS, MONTANA

PROGRAM DESCRIPTION

March 2, 1978

Intermediate Level Group - Region II - Monday through Friday, 1:00-1:30 p.m.

This is a meeting of residents of Region II who have attained intermediate level standings in the regional level system. Residents on this level have an opportunity to earn two hours of ground parole and twenty-four hours of smoking privileges based on attendance in their scheduled therapeutic activities.

Each resident has an individualized check list with his or her schedule of therapeutic activities printed in a vertical column. The horizontal column represents the days of the week (Monday through Friday). On each weekday the Mini - Team staff members ask the resident if he or she has attended those specific therapeutic activities scheduled for that particular day. The resident receives a check for attending the activity and a zero for not attending the activity. Each activity has a predetermined positive reinforcement of ground parole or smoking privileges which is awarded contingent on that day's attendance in therapeutic scheduled activities.

After a two-week baseline period each resident has a behavioral objective to maintain, or decrease the number of zeros on his or her check list for the two-week consecutive period following. These objectives may be found in the progress notes under, "Intermediate Level Behavioral Check List Objectives".

Steve Stauber, RMT

ST/lc
3/2/78
2/3T03

Steve Stauber RMT

WARM SPRINGS STATE HOSPITAL
WARM SPRINGS, MONTANA

PROGRAM DESCRIPTION

March 2, 1978

Music Therapy Group - Region II - Tuesday and Thursday, 2:00-3:00 p.m.

This is a Music Therapy Group for residents of Region II held on the above days in the Region II conference room. This Group is limited to six members. All Region II residents are eligible for an evaluation to be included in this Group. Acceptance is based on, (1) availability of a vacancy, (2) the resident's ability to benefit from a Group Music Therapy situation.

Common Group goals include:

(1) Increased socialization skills
(2) Increased communication skills
(3) Increased attention span
(4) Increased relaxation skills
(5) Increased appropriate emotional expression
(6) Increased awareness of self and environment
(7) Increased self-image

Individual objectives may include increased number of appropriate verbalizations on request or, spontaneously. Increased appropriate eye contact during communication. Decreased number of interruptions, subject changes or wandering of attention episodes. Decreased time spent shaking limbs nervously, increased identification of internal feeling states and increased appropriate expression of feelings. Also, increased reality orientation, increased involvement in successful music activities.

Group activities may consist of, discussion, music listening, instrument playing, singing etc. Behavior modification techniques involving appropriate use of positive reinforcement will be strictly employed.

Steve Stauber, RMT

Steve Stauber RMT

ST/lc
3/2/78
2/5577

APPENDIX C

Region V Program

Reg V

POLICY STATEMENT

It shall be the policy on Region 5 that all patients be classified at one of four step levels. Each step level will have a clearly defined set of responsibilities and privileges. All patients will be placed at the step level which corresponds with their level of functioning. The only exceptions to this policy will be:

1. Court ordered commitments for examination and evaluation. Because of the legal status of their commitment we are prevented from offering a more complete treatment program. R&E patients may leave the building only to go to the dining room.

2. Lower Functioning patients for whom this system will not be practical.

In an effort to help with this new step level system Region 5 patients will form a Resident Advisory Council. This council will have a membership of seven people - 2 from Unit 35, 2 from Unit 34, and 3 from Unit 33.

The Resident Advisory Council will meet on a regularly scheduled basis every week. The council will be responsible for bringing patient problems to the attention of the staff. They will be responsible for making recommendations to the staff as to how to deal with patient problems. They will also be responsible for recommending promotion or demotion from the step levels.

It must be stressed that this council may act only in an advisory capacity. In all matters the staff will be responsible for making final decisions.

CLOSED WARD POLICIES

The following policies have been submitted and passed by the Patient Advisory Council and the Region V Treatment Team.

1. Open T.V. hours in the evening after 10 pm.

2. Personal watch and wallet may be taken out of the Ad. building by those individuals on level 2, with the written and signed agreement of that individual releasing the staff of all responsibility.

3. Phone calls can be made at anytime except between 11 pm. to 7 am. Individuals are entitled to privacy at this time, that being, they are able to be in the office alone with the door closed.

4. Sleeping hours on the week days will allow the individual to sleep up to 7:15 am.

5. Sleep in hours on the week-end will be for all those who choose to do so, with the exception of diabetics, who must attend breakfast, but may return to bed upon returning to the ward. Individuals may sleep no later than 11 am. Those who are in need of certain medications are required to rise when meds are given. Sign up sheets will be posted each week-end. Individuals will sign their names if they request to sleep in.

6. The visitors room will be opened to all individuals at anytime. Should the use of the room be required for visitors of staff, it is the understanding that those in the room shall leave the area. It is also an understanding that there will be no Smoking in this area.

7. Those who are members on the Patient Advisory Council may move to the open wards at what times they so choose and for the length of time they so choose, with the understanding that they be only involved with council matters.

PATIENT CLASSIFICATION BY STEP LEVELS

I. Policy: Levels of responsibility and accompanying privileges have been developed to aid the staff in giving consistent and objective responses to all patients; also by virtue of these levels each patient should be more aware of what is expected of him and what privileges he has in his treatment plan.

II. Procedure: Four levels have been established. Level I being the lowest and level IV the highest.

LEVEL I

A. Pertinent to;
1. All new patients.
2. All patients not in a higher level.
3. All patients transferred from another unit.
4. All patients meeting established requisites in this level.

B. Responsibilities;
1. They shall take their medications.
2. They shall not engage in acting out or destructive behavior, eg., throwing and breaking things, persistent swearing, temper tantrums, hitting others, and so on.
3. They shall make their own beds and help maintain the ward.
4. Participation in all assigned and therapeutic programs and ward duties for seven days or more while in Level I.

C. Privileges;
1. Dining Room.
2. Coffee--@ 2:30 p.m..
3. Television.
4. Able to sit on porch.
5. One cigarette an hour on the half hour.

D. Non-Privileges;
1. No ground parole.
2. No home visits.
3. No discharge possibility except by court order.
4. Must be on a closed ward.

E. Promotion Requirements to next Level;
1. New patients successfully fulfill step level-I responsibilities for at least seven days.
2. Transfer patients successfully fulfill step level I responsiblities for at least two days.

STEP LEVEL TWO SHALL PERTAIN TO THOSE STEP LEVEL I PATIENTS WHO ARE PROMOTED THROUGH ACTION TAKEN BY THE RESIDENT ADVISORY COUNCIL.

LEVEL II.

A. Pertinent to;

1. All patients who have been in residence for seven days or more.
2. All patients not in a lower or higher level.
3. All patients meeting established requirements.

B. Responsibilities:

1. Participation in all assigned theraputic programs and ward duties assigned upon reaching Level II in addition to those assigned while on Level I for seven or more days.
2. They shall take their medications.
3. They shall not engage in acting out or destructive behavior, ex., throwing and breaking things, persistent swearing, temper tantrums, hitting others and soon.
4. They must maintain good personal grooming.
5. They must observe all rules and regulations of WSSH and specifically those of Region V.
6. They must show consideration for the comfort and needs of the other patients.

C. Privileges;

1. Dining Room.
2. Coffee--@ 2:30 p.m.
3. Television.
4. Able to sit on porch.
5. One cigarette an hour on the half hour.
6. Ground parole-- one to three hours with or with out buddy upon discretion of RX team.
7. Supervised activities- dances, shows, canteen.
8. Two day home visit and two day travel time at discretion of RX team.
9. Patient employment with approval of RX team.

D. Non-Privileges;

1. No discharge possibility except by court order.
2. Must be on closed ward.

E. Promotion Requirements to next Level;

1. Successfully fulfill step level two requirements for seven or more days.
2. Request approved by resident council.
3. Resident council recommendation endorsed by RX team.
4. If request rejected, patient may reapply for promotion to the resident council at the time of their next regularly scheduled meeting.

STEP LEVEL THREE SHALL PERTAIN TO THOSE LEVEL TWO PATIENTS WHO ARE PROMOTED THROUGH ACTION TAKEN BY THE RESIDENT ADVISORY COUNCIL.

LEVEL III.

A. Pertinent to;

1. All patients who have functioned in Level II for seven or more days.
2. All patients not in a lower or higher level.
3. All patients meeting established requirements.

B. Responsibilities;

1. Participation in all assigned theraputic programs and ward duties assigned upon reaching level III in addition to those assigned while on level I and II for seven or more days.
2. They shall take their medications.
3. They shall not engage in acting out or destructive behavior, eg., throwing and breaking things, persistent swearing, temper tantrums, hitting others so on.
4. They must maintain good personal grooming.
5. They must observe all rules and regulations of WSSH and specifically those of Region V.
6. They must show consideration for the comfort and needs of the other patients.
7. Take a positive and realistic and active part in setting one or more goals for self-improvement while in the hospital and work on its attainment.

C. Privileges;

1. Dining Room.
2. Coffee--@ 2;30 p.m.
3. Television.
4. Able to sit on porch.
5. One pack of cigarettes a day.
6. Ground parole--four hours to full ground on closed ward.
7. Supervisied activities-dances, shows and canteen.
8. Opportunity for more choice in theraputic programs participation.
9. Possible transfer to open ward.
10. Patient emoloyment with approval of RX team.
11. Off-grounds activities.
12. Seven day home visit, included travel time, at discretion of the RX Team.

D. Non-Privilezes;

1. No discharge possibility except by court order.

E. Promtion Requirements to next Level;

1. Successfully fulfill step level requirements for fourteen or more days.
2. Step level IV shall pertain to those step level III patients who are promoted through action taken by the resident council.
3. Resident council recommendation endorsed by RX team.
4. If request rejected, patient may reapply for promotion to the resident council at the time of their next regularly scheduled meeting.

STEP LEVEL IV SHALL PERTAIN TO THOSE STEP LEVEL III PATIENTS WHO ARE PROMOTED THROUGH ACTION TAKEN BY THE RESIDENT ADVISORY COUNCIL.

LEVEL IV:

A. Pertinent to;
   1. All patients who have functioned in level III for fourteen or more days.
   2. All patients not in a lower level.
   3. All patients meeting established requirements in this level.

B. Responsibilities;
   1. Participation in all assigned therapeutic programs and ward duties assigned upon reaching level Iv in addition to those assigned while on levels I II and III.
   2. They shall take their medications.
   3. They shall not engage in acting out or destructive behavior, eg., throwing and breaking things, persistent swearing, temper tantrums, hitting others and so on.
   4. They must maintain good personal grooming.
   5. They must observe all rules and regulations of WSSH and specifically those of Region V.
   6. They must show consideration for the comfort and needs of the other patients.
   7. Take a positive and realistic and active part in setting one or more goals for self-improvment while in the hospital and work on its attainment.

C. Privileges;
   1. Open Ward.
   2. Home visits.
   3. Discharge or placements.
   4. More choice in therapeutic program participation.
   5. Off-ground activities.
   6. Patient employment.

THIS IS THE HIGHEST LEVEL POSSIBLE!

   8. Actively participate with the social worker in release and aftercare planning.

APPENDIX D

Intensive Treatment Unit Program

I.T.U. Program Manual

This information manual is designed to help mental health professionals, clinics, and agencies dealing with the Schizophrenic patient, develop a better understanding of the resource available to them at Warm Springs State Hospital for the treatment of the acute schizophrenic patient. Hopefully, this manual will assist you in understanding the policies and procedures of the Intensive Treatment Unit (I.T.U.), and heighten your awarenss of an existing resource available to your community in actively treating the schizophrenic patient.

If you have any comments or questions regarding the information contained in the manual, or wish further information about the Intensive Treatment Unit, please feel free to contact the I.T.U. Program at Warm Spring State Hospital.

Phone: 693-2221 - Extensions, 2416, 2465, 2463, or
Write: I.T.U. Warm Springs State Hospital
Warm Springs, Montana 59756

Thank You!

Statement of Goals:

1. To provide an intensive therapeutic treatment setting for the rehabilitation of the schizophrenic patient.

2. Foster a therapeutic milieu which facilitates growth into interdependent functioning by reducing symptomatic behavior and improving self-care skills, appropriate social behavior, and problem-solving skills.

3. Development of a cohesive relationship among staff, patients, family, hospital, and the community.

4. Provide training, education, and developmental experiences for hospital staff and community.

5. Provide an atmosphere for training and education for students of all disciplines.

6. Provide an atmosphere for research.

7. Return patients to the community or regional wards.

Admission:

When a patient is admitted to Warm Springs State Hospital and to their respective Region (Ward), and meet the criteria set forth for admission to the Intensive Treatment Unit, they can be referred immediately following the mental status examination, to the Intensive Treatment Unit. An assessment team from I.T.U. will evaluate the patient and if appropriate, the patient can be transferred to the I.T.U. program, providing a bed is available.

Patients are considered for placement on I.T.U. on a referral from the mental status examiner and/or the Region. In the event bed space is not available a priority waiting list will be set up and acuteness of the case will be considered. Former Intensive Treatment Unit patients with long-term treatment plans (goals), returning to Warm Springs State Hospital, will be expected to return to the Intensive Treatment Unit.

The DSM-II will be the primary source for screening patients for the schizophrenic unit. Also, a memo on the Endicott-Spitzer criteria, will be utilized and will be made available to all the Regions.

Exclusions for admission to I.T.U. are: *

1. Organic Brain Syndrome - Retardation IQ below 80.

2. Criminal Court Orders will be accepted only after team evaluation for appropriateness.

3. Character Disorders.

4. Psychosis caused by alcohol and/or other drug involvement.

5. Psychoneurosis.

6. Schizo-affective Disorders.

7. Manic-Depressive.

8. Multiple Diagnosis, except when schizophrenia is regarded as the primary diagnosis.

9. Security patients who need maximum security precautions.

* May be exceptions after team evaluation.

UNIT RULES

1. All patients are expected to attend meals and activities in street clothes.

2. All group meetings are mandatory.

3. Physical abuse or threats of abuse to persons or property is not acceptable.

4. Sexual activity is not permitted.

5. There is to be no use of alcohol or non-prescribed drugs.

6. For safety and comfort of others, smoking will be done in designated areas only.

7. Patients are expected to be up and dressed and bed made by 7:30 a.m. on weekdays and 10:00 a.m. weekends and holidays.

8. You are expected to sleep in your bed only.

9. Quiet time begins at 10:30 p.m. daily.

10. Patients may not enter anyone elses room without occupants permission.

11. Television is to be off during scheduled activities.

12. Patients are not allowed in Nurses Station except when staff permission is given.

PRIVILEGE LEVEL SYSTEM FOR I.T.U.

There are four levels of privileges. The level you are on is determined by you, the team, and the Community Advisory Council. This determination is based upon your behavior and the degree to which you participate in your treatment program. Initially, everyone is assigned to Level D, and there is a mandatory 24-hour period between level changes. Requests for level changes must be initiated by the patient, both for increased or decreased privileges. However, staff may lower your level anytime you are judged to be harmful to yourself or others, or not meeting the requirements of your level.

LEVEL D

Allowed supervised activities and $5.00 canteen book, at staff discretion. Patients are required to stay on the unit unless escorted by staff to occupational therapy, meals, supervised activities, and other off unit consults.

Patients at this level are working toward meeting the requirements of Level C. This level includes patients newly admitted, patients on suicide levels, escape precautions, and those who have participated in a major incident, which is defined as an incident in which the patient is harmful to himself or others. There will be 48-hour mandatory time on this level.

LEVEL C

One hour of Ground Parole with or without an escort, at staff discretion. Allowed $5.00 cash.

1. Must be dressed in street clothes - with or without staff or patient assistance.

2. Must maintain a reasonably appropriate appearance and behavior - with or without staff or patient assistance.

3. Room clean and bed made - with or without staff or patient assistance.

4. Attend all meetings on time and dressed in street clothes.

   a) Group and patients/staff meetings
   b) Community Advisory Council - C.A.C.
   c) Occupational Therapy
   d) Psychological Testing
   e) Family Conferences
   f) Meetings with Therapist

5. Abide by all unit rules.

6. Have not attempted to harm self or others, or threatened to do so within 24-hours; at staff discretion.

7. Perform Community Jobs, if assigned.

8. Begin to set goals in defined problem areas, and engage in off ward program schedules.

9. Attend, on time and dressed appropriately, recreational activities and supervised activities.

LEVEL B

Two hours of limited Ground Parole. Allowed $10.00 cash.

1. Must meet all requirements of Level C.

2. Be an active member of the community:

   a) By participating in meetings and groups in trying to solve your problems.
   b) By getting to know the people living and working here, and letting them know you.
   c) By showing an interest in the events going on around you.

3. Continue to set your goals in your problem areas. Development and participation in a written treatment plan with therapist and other community members.

4. Participating in school program, patient employment or work shop activities off the unit.

5. Begin making plans for discharge (for example - living arrangements, etc...).

If the above requirements of this level are not met, returning to Level C or D is the consequence.

LEVEL A

Has full Ground Parole with store and Bird Farm privileges. Allowed $10.00 cash.

1. Meet requirements of Levels D, C, and B

2. Working effectively towards completing your treatment programs.

3. Independent Project: This is to engage in an independent project, such as an active community duty, such as escorting, or being responsible for helping a patient in his dressing and other appropriate behaviors, such as assisting in cleaning his/her room. This will be for one hour a day, seven days a week.

4. Planning for discharge - Living arrangements, follow-up therapy, etc.. Must demonstrate concrete plans or arrangements.

5. Working off grounds in work shop or school setting.

If above requirements of this level are not met, returning to Level B, C, or D is the consequence.

FAMILY CONFERENCES

General Goals:

1. To directly involve the patients family and friends in the overall therapeutic process.

2. To involve patients family and friends in the initial diagnostic - assessment of the patient.

3. To improve communication between the patient, his family, friends, and Hospital staff.

4. To involve patients family in the discharge planning process.

Procedures:

1. The patients family will be required to attend scheduled family conferences.
   a) Minimum attendance at assessment and discharge conferences is expected.
   b) Encourage families to attend additional family conferences to facilitate the above goals.

VISITORS POLICY

Family and friends are welcome and encouraged to visit during recommended visiting hours.

Recommended Visiting hours are 1:00 p.m. - 8:00 p.m. daily (1:00 p.m. - 7:00 p.m. during winter hours daily).

Patients are obligated to adhere to their treatment schedule.

Visiting is to be done in designated Visitors Lounge.

Patients on any suicidal level must be accompanied by a staff member. Visiting time may be limited at discretion of staff.

New admissions will have visiting privileges at discretion of staff during his/her first 48-hours on unit.

Patients in seclusion and/or restraints will not be allowed visitors at any time.

For your convenience, prior notification of visits would be appreciated. Thank You!

DISCHARGE POLICY

Formulation of a Discharge Plan will begin when the Social/Interim History is initiated through patient/team interview, family interview, and community agency contact.

Social Service will take the ultimate responsibility for discharge planning.

Discharge from the Intensive Treatment Unit may be initiated by the patient, case coordinator, or Community Advisory Council.

A referral, either written or verbal, will then be presented to the treatment team for its consideration. The patient will be seen by the treatment team for the purpose of an assessment interview in order to evaluate the patient's ability to function in a community environment.

Results of evaluation from all disciplines will be taken into consideration by the treatment team in order to determine appropriateness of discharge.

Community Advisory Council (C.A.C.)

The entire patient community functioning as a task oriented problem-solving group.

Functions:

To organize and develop unit activities, recommend step-level changes, and provide feedback regarding unit routine.

Organizat n:

All patients will attend the Community Advisory Council meetings, along with the Psychiatric Aide III on afternoon shift and other designated personnel, who will act on a consulting basis.

Policies:

1. C.A.C. will meet weekly on Tuesday nights at 8:00 p.m.

2. Any community member may present at any meeting a suggested policy, request for action, or plan directly to the community.

3. C.A.C. will follow the practice of accepting a simple majority vote in deciding issues.

4. The Treatment Team retains the right to veto measures brought forth by the council.

The Sensory Intergration Program

The Schizophrenic illness, in some people, has a tendency to affect the ability to receive, process, and respond appropriately to information conveyed through the body senses. When this happens, posture, speed of movement and behavior is altered.

When a patient arrives on the I.T.U., he or she is evaluated by the Occupational Therapist within eight working hours to assess whether or not there is a sensory deficit.

If problems are found the person is assigned to a therapy group which involves a structured program of sensorimotor treatment. Modalities focused on, include:

1. The Vestibular System - which is concerned with detecting motion through space in relation to the gravitational pull on the body.

2. Proprioception - involving positioning of the body by using the receptors in our muscles, joints, ligaments, and bones.

The Sensory Intergration Program cont.

3. The Tactile System - which gives us the ability to discriminate through touch.

4. Vision - perceiving position and form with sight.

5. Olfaction - our system of smell.

Baseline information is recorded on all individuals entering this program in order to monitor progress throughout treatment.

APPENDIX E

Medication

TABLE ONE

Summary of Documented Drug History

Patient Number	Medication	Allergy	Adverse Drug Reactions	Drug Abuse
2-15731	N	N	N	N
C 24612	N	N	N	N
C 30992	N	P	N	P
C 30115	N	P	N	N
2-32375	N	P	N	N
3-23809	N	N	N	N
3-20029	N	P	N	N
3-21503	N	N	N	N
3-36640	N	P	N	P
5-36965	N	P	N	N
3-34344	N	P	N	N
5-29888	N	N	N	N
5499	N	P*	N	N
C 35768	N	N	N	N

Key: P is present

N is not present

* is not complete

Number: 2-15731 Location: Region 2 Admitted: 6-25-76

Diagnosis: Schizophrenia, chronic undifferentiated
Status Post Lobotomy, 1950

Medications: Mesoridazine (Serentil^{R})
Trihexyphenidyl HCl (Artane^{R})
MOM with Cascara

A. History

1. Medication: May be obtained only by reviewing the entire chart.

2. Allergy/Adverse Drug Reaction: Not present

3. Drug Abuse: Not present

B. Current Medications

1. Indication:

--Mesoridazine--Appropriate for diagnosis and current symptoms. In view of the hyperactivity described, a more sedative phenothiazine, such as chlorpromazine, may be a better choice.

--Trihexyphenidyl HCl--No indication documented. Extrapyramidal side effects to antipsychotic agents, the usual indication, are not described and are less likely to occur with this class of phenothiazine than with most other phenothiazines.

--MOM with Cascara--For constipation (See 4. Adverse Drug Reaction). Most authorities would prefer a bulk forming laxative, eg., metamucil and/or a stool softener such as dioctyl sodium sulfosuccinate.

2. Contraindications: None apparent

3. Drug Interactions: Intended (Trihexyphenidyl HCl and Mesoridazine), but probably not necessary (See 1. Indications).

4. Adverse Drug Reaction: Constipation is most likely secondary to mesoridazine and/or Trihexyphenidyl HCl. This is a side effect which, although troublesome to the patient, does not usually cause any real harm. Since the indication for Trihexyphenidyl HCl is not well defined it could be suggested that this side effect could have been avoided.

5. Dosage: The dose of Mesoridazine has been gradually increased one the past year in an effort to control symptoms, i.e., hyperactivity (See Indications), but is still within acceptable range.

6. Prescriber: Orders signed monthly

7. Review: All medication orders are rewritten by the nurses once monthly and signed by the physician.

8. Goals: General goals defined in treatment plan.

9. Medication Record: Present

C. Integration: Not documented

D. Comments: Records are not in any reasonable order. Progress notes are not in chronological order.

Number: C 24612 Location: Region 2 Admitted: 3-16-69

Diagnosis: Schizophrenia, chronic undifferentiated

Medications: Thioridazine (Mellaril^{R})
Trihexyphenidyl HCl (Artane^{R})
Desenex^{R} Foot Powder
Various others recently, but not currently

A. History

1. Medications: May be obtained only by reviewing the entire chart.

2. Allergy/Adverse Drug Reaction: Not present

3. Drug Abuse: Not present

B. Current Medications

1. Indications:
--Thioridazine--matches diagnosis.
--Trihexyphenidyl HCl--for adverse reactions from thioridazine on an as needed basis. These adverse reactions are less likely to occur with Thioridazine than with most other phenothiazines, and therefore this drug is probably not needed.
--Desenex^{R} Foot Powder--No indication described.

2. Contraindication: There is a questionable history of a "heart attack", but with a normal electrocardiogram. Thioridazine frequently has adverse effects on the heart's rhythm, but none is documented in this patient. In view of the questionable history, the potential benefit probably outweighs the risks.

3. Drug Interactions: Intended (Thioridazine and Trihexyphenidyl HCl)

4. Adverse Drug Reactions

--Frequent urinary tract infections: Urinary statis is well known to predispose to urinary tract infection. Thioridazine and, in the past, Trihexyphenidayl HCl, Loxapine succinate, and haloperidol have tended to cause urinary retention (stasis) and contributed to these frequent infection.

--Apparently a dystonic reaction, urinary retention, and rash on 1-18-78. This reaction followed an increase in dosage of haloperidol from 10 mg three times daily to 15 mg three times a day on 1-10-78, and up to 15 mg four times a day on 1-17-78. The relationship between dosage increase and the onset of these reactions implicates haloperidol. The reaction was treated with Trihexyphenidyl HCl (previously prescribed on an as needed basis)

and with diphenhydramine HCl (Benadryl^{R}). The use of two anticholonergics, Trihexyphenidyl HCl and diphenhydramine HCl, was probably not necessary and may have aggravated the already existing urinary retention. A single agent is best. The psychiatrist did document the reaction in the progress notes, but not until 1-19-78. This note indicates only a mild degree of amelioration of symptoms. No further notes indicate recovery or further improvement.

5. Dosage: Currently appropriate.

   In the past the dosage of haloperidol was increased on two occasions, one week apart. This is a reasonable increment. If, however, a trained observer (psychiatrist or others) had re-examined the patient on 1-17-78 before increasing the dosage the second time, he or she may have noted some degree of dystonia and averted the severe reaction which occurred on 1-18-78. (See Adverse Drug Reactions).

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurses once monthly and signed by the physician. An apparent lack of appropriate monitoring of drug therapy is described in the sections on dosage and adverse drug reaction.

8. Goals: General goals defined in treatment plan.

9. Medication Record: Present

C. Integration: Not documented.

D. Comments: Over an hour was spent reviewing this chart and trying to put things together. The chart was very disorganized and not in chronological order. The progress notes do not document reasons for changing medications and dosages.

Number: C 30992 Location: Region 2 Admitted: 7/1/75

Diagnosis: Schizophrenia, chronic undifferentiated

Medications: Haloperidol (Haldol^{R})
Benztropine mesylate (Cogentin^{R})
Desenex^{R} Foot Powder
Chloramphenicol Ophthalmic Solution
MOM with Cascara

A. History

1. Medication: May be obtained only by reviewing the entire chart.

2. Allergy/Adverse Drug Reaction: No allergies; drug reactions not mentioned.

3. Drug Abuse: Suicide attempt with Sominex^{R} on a home visitation in 2-78 is documented.

B. Current Medications

1. Indications

--Haloperidol--appropriate for diagnosis and documented symptoms.
--Benztropine mesylate--appropriate since haloperidol is quite likely to produce side effects which can be at least partially reversed by benztropine mesylate.
--Desenex^{R} Foot Powder--no indication described.
--Chloramphenicol Ophthalmic Solution--a reasonable initial choice for conjunctivitis. The culture and sensitivity, however, revealed an organism which was only intermediately sensitive to chloramphenicol. When this result was available a reassessment should have been made--if the eye was improving, Chloramphenicol could have been retained; if the eye was not improving, switching to another antibiotic to which the organism was more sensitive would have been indicated. No progress note describing improvement or lack thereof was made.
--MOM with Cascara--for constipation (See adverse drug reactions). Most authorities prefer the use of a bulk forming laxative, eg., metamucil and/or a stool softener, eg., dioctylsodium sulfosuccinate.

2. Contraindications: None described

3. Drug Interactions: Intended (Haloperidol and Benztropine mesylate).

4. Adverse Drug Reactions: Apparently developed constipation secondary to haloperidol and benztropine mesylate (the latter being the more likely). This side effect is bothersome to the patient, but is not usually of any real harm to the patient.

5. Dosage: All within reason.

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurses monthly and signed by the physician.

8. Goals: General goals defined in treatment plan.

9. Medication Record: Present

C. Integration: Not documented.

D. Comments: Medication orders have been changed frequently with little documentation of the need to do so. Seclusion and restraints have been used on several occasions.

Number: C 30115 Location: Region 2 Admitted: 3-13-71

Diagnosis: Schizophrenia, paranoid type

Medications: Haloperidol (Haldol^{R})
Trihexyphenidyl HCl (Artane^{R})
Chlorpromazine (Thorazine^{R})
Ovral^{R}
MOM with Cascara

A. History

1. Medication: Only with reviewing entire record

2. Allergy/Adverse Drug Reactions: No known allergies; drug reactions not mentioned.

3. Drug Abuse: Not present

B. Current Medications

1. Indications

--Haloperidol--matches diagnosis.

--Trihexyphenidyl HCl--Indicated for probable side effects of haloperidol.

--Chlorpromazine--would also be a good initial drug for this diagnosis, but the combination of haloperidol and chlorpromazine would be hard to justify.

--Ovral^{R}--an oral contraceptive; it is not clear to me why a contraceptive is necessary in an institutionalized patient.

--MOM with Cascara--for constipation. Most authorities prefer a bulk forming laxative, eg., metamucil and/or a stool softener eg., dioc tylsodium sulfosuccinate.

2. Contraindications: None apparent

3. Drug Interactions: Haloperidol and/or chlorpromazine with trihexyphenidyl HCl intended. Haloperidol with chlorpromazine--additive effects probably intended but it is hard to justify using these two antipsychotics together (See Indications).

4. Adverse Drug Reactions: None documented, but hinted at with the order: "Haldol concentrate 10 mg AM, 15 mg PM, omit one dose if too drowsy." Drowsiness is a common side effect which is common to all antipsychotics and is sometimes desirable. It is more commonly seen with chlorpromazine than with haloperidol, therefore it would be more logical to withold a dose of chlorpromazine.

5. Dosage: All are within acceptable range.

6. Prescriber: Orders not always signed monthly as is the usual case. Three different physicians have signed orders in the last few months.

7. Review: All medication orders are rewritten by the nurses monthly, but not always signed by the physicians. Review is unlikely since three physicians have been involved.

8. Goals: General goals described

9. Medication Record: Present

C. Integration: Not documented

Number: 2-32375 Location: Region 2 Admitted: 1-26-77

Diagnosis: Schizophrenia, chronic undifferentiated

Medications: Haloperidol (Haldol^{R})
Benztropine mesylate (Cogentin^{R})
Prior to 4-13-78
Phenobarbital
Benztropine mesylate (Cogentin^{R})
A & D Ointment
Perphenazine (Trilaton^{R})

A. History

1. Medication: Only with reviewing the entire chart

2. Allergy/Adverse Drug Reaction: No allergies; drug reactions not mentioned.

3. Drug Abuses: Not documented.

B. Current Medications

1. Indications

--Perphenazine--Matches the diagnosis, but with agitation a more sedative antipsychotic may have been more appropriate and probably would have obviated the need for phenobartital.

--Phenobarbital--Apparently for its sedative action in an attempt to relieve agitation.

--Benztropine mesylate--both perphenazine and haloperidol are quite likely to cause side effects which will be at least partially reversed by Benztropine mesylate.

--A & D Ointment--apparently for some condition on the left heel.

--Haloperidol--a rational, probably belated, replacement for perphenazine and phenobarbital.

2. Contraindications: None apparent

3. Drug Interactions: Benztropine mesylate with perphenazine or haloperidol intended (See Indications). Perphenazine with Phenobarbital--additive sedation intended (See Indications).

4. Adverse Drug Reactions: None documented.

5. Dosage: All within reasonable range.

6. Prescriber: Orders signed monthly.

7. Review: All medications orders are rewritten by the nurses monthly and signed by the physician. A good review of the situation should probably have resulted in the change to haloperidol several weeks sooner.

8. Goals: General goals defined.

9. Medication Record: Present

C. Integration: Not documented

Number: 3-23809 Location: Region 3 Admitted: 9-12-62

Diagnosis: Schizophrenia, paranoid type

Medications: Fluphenazine (Prolixin Decanoate^{R})
Chlorpromazine (Thorazine^{R})
Mesoridazine (Serentil^{R})

A. History

1. Medication: Only with reviewing the entire record.

2. Allergy/Adverse Drug Reaction: Not present

3. Drug Abuse: Not present

B. Current Medications

1. Indications: An antipsychotic would be indicated based on diagnosis, but the use of three antipsychotics is difficult to justify, even though one of them (chlorpromazine) is as needed for acting out or delusional behavior.

2. Contraindications: None apparent

3. Drug Interactions: Additive effects of the three antipsychotics intended.

4. Adverse Drug Reactions: None documented well. Apparent drowsiness on 1-3-78 noted by physician in progress notes, but no action taken. On 7-7-77 "akikisia" is noted by the physician who "reviewed medications and made adjustments." This term in unfamiliar nor can it be located in any dictionary. I suspect that either akinesia akathisia is what is meant, both of which would most likely be an extrapyramidol side effect of one of the antipsychotics.

5. Dosage: All within acceptable range. The dosage of fluphenazine decanoate is written as 1 cc. Since the drug is available only as a 25 mg/cc solution, the actual dose is apparent. However, it is preferable that the dose be expressed in mg so that if a more contrated solution is subsequently marketed, no confusion will result. Fluphenazine decanoate has been prescribed to be given by intramuscular injection every week. In most cases an injection every three or four weeks is sufficient. An every week regimen is, however, much easier for the nursing staff in terms of compliance.

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurses monthly and signed by the physician.

8. Goals: General goals defined

9. Medication Record: Present

C. Integration: Not documented

Number: 3-20029 Location: Region 3 Admitted: 6-4-76

Diagnoses: Moderate mental retardation
Nonpsychotic Organic Brain Syndrome
Epilepsy, Grand Mal Type

Medications: Phenobarbital
Ethosuximide (Zarontin®)
Chlorpromazine (Thorazine®)

A. History

1. Medication: Only with reviewing entire record.

2. Allergy/Adverse Drug Reaction: Allergic to ivory soap; drug reactions not mentioned.

3. Drug Abuse: Has spent most of his life in institutions, therefore probably not significant.

B. Current Medications

1. Indications

--Phenobarbital and Ethosuximide for epilepsy. This is not an unreasonable regimen assuming a single drug was tried initially.

--Chlorpromazine--no indication apparent.

2. Contraindications: Chlorpromazine can predispose susceptible individuals to more seizures and therefore needs to be used with caution. In this case there has apparently been no problem. However, in the absence of a definite indication, one must wonder what benefit there is that exceeds this risk.

3. Drug Interactions: Chlorpromazine would potentiate the sedative effects of phenobarbital. Since phenobarbital is being used as an antiepileptic in this case, sedation is an undesirable effect. Phenobarbital has been shown to decrease the blood level of chlorpromazine, and therefore the effect of chlorpromazine.

4. Adverse Drug Reactions: None apparent

5. Dosage: Within acceptable range

6. Prescriber: Orders signed monthly

7. Review: Not documented. Blood levels of anticonvulsants (Phenobarbital and previously Phenytoin] are taken every three months.

8. Goals: Not explicitly stated

9. Medication Record: Present

C. Integration: Not documented

D. Comments: On one occasion (2-23-78) a note stated "Zarontin not gotten from pharmacy, therefore not given." Missing a single dose or even one day's worth of an anticonvulsant is not likely to be harmful, but since the pharmacy is only a few blocks away it seems to me to be prudent to call over and obtain some.

I cannot determine why this patient is at WSSH. I do not see where any diagnoses he carries should confine him to an institution.

Number: 3-21503 Location: Region 3 Admitted: 4-17-69

Diagnosis: Schizophrenia, chronic undifferentiated

Medications: Haloperidol (Haldol^{R})
Trihexyphenidyl HCl (Artane^{R})
Desenex^{R} Foot Powder
Terra-Cortril^{R} Ointment
Aspirin

A. History

1. Medication: Only with reviewing the entire record.

2. Allergy/Adverse Drug Reaction: None present

3. Drug Abuse: None present

B. Current Medications

1. Indications

--Haloperidol--matches the diagnosis and current symptoms.

--Trihexyphenidyl HCl--often necessary for control of side effects of haloperidol. Usually, however, after several months one can withdraw the trihexyphenidyl HCl without problems.

--Desenex^{R} Foot Powder--athlete's foot.

--Terra-Cortril^{R} Ointment--for some condition on his face.

--Aspirin--no indication stated.

2. Contraindications: All antipsychotics have a potential for disturbing the heart's rhythm especially in persons who already have some abnormality of the heart. There is a history of heart problems here that, as best as I can put it together, originated with rheumatic fever at age four and five, which led to mitral stenosis (malfunctioning of one of the heart valves), which resulted in a mild degree of heart failure (as evidenced by a slightly enlarged heart on chest x-ray on 10-26-77) and also resulted in at least one episode of Atrial Fibrillation (a rhythm disturbance of the heart) with rapid ventricular response of 150 to 180 (a serious, possibly life-threatening consequence of the rhythm disturbance) as documented by electrocardiogram on 7-11-77. When questioned, the nurse was not aware of this history. Haloperidol is perhaps a good choice for an antipsychotic since it has less cardiovascular effects than most other antipsychotics. In the presence of this history, more careful monitoring of the cardiac status is required.

3. Drug Interactions: Haloperidol and Trihexyphenidyl HCl (intended).

4. Adverse Drug Reactions: None documented, although it is conceivable that the episode of atrial fibrillation on 7-11-77 could have been prompted by antipsychotic medications.

5. Dosage: Acceptable

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurses and signed by the physician.

8. Goals: General goals stated.

9. Medication Record: Present

C. Integration: Not documented

Number: 3-36640 Location: Region 3 Admitted: 4-8-76

Diagnosis: Acute Brain Syndrome
Chronic Severe Depression
Nonpsychotic Organic Brain Syndrome with Brain Trauma

Medications: Thioridazine (Mellaril^{R})
Amitriptyline (Elavil^{R})
Vitamin B_{12}
Pemoline (Cylert^{R})

A. History

1. Medication: Only with reviewing the entire chart.

2. Allergy/Adverse Drug Reactions: No allergies; drug reactions not mentioned.

3. Drug Abuse: Tried to overdose on aspirin (Bufferin^{R}) in 1975.

B. Current Medications

1. Indications

--Thioridazine--for "increasingly withdrawn pattern"
--Amitriptyline--for chronic severe depression is the drug of choice since depression is accompanied by anxiety.

--Vitamin B_{12}--no indication documented.
--Pemoline--probably for "Acute Brain Syndrome." The only indication for this drug is in children with the syndrome of minimal brain dysfunction. Its use in this patient seems inappropriate.

2. Contraindications: None apparent

3. Drug Interactions: Amitriptyline and Thioridazine would be additive in terms of side effects. Pemoline would tend to counteract the sedative effects (though minimal) of these two drugs.

4. Adverse Drug Reactions: Pemoline may be responsible for the anxiety and nervous component the complex of symptoms.

5. Dosage: Acceptable

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurses and signed by the physician. It appears to me that several adjustments in drug therapy need to be considered. Is Vitamin B_{12} needed? A therapeutic trial without pemoline appears to be indicated.

A reassessment of diagnoses is needed. Does this person have a schizo affective disorder (in which case the amitriptyline would no longer be needed) or is this an endogenous depression (in which case it may be worth trying to wean the patient from thioridazine).

8. Goals: Need to be redefined.

9. Medication Record: Present

C. Integration: Not documented

Number: 5-36965 Location: Geriatrics Admitted: 7-7-77

Diagnoses: Organic Brain Syndrome with cerebral disturbances (antagonistic behavior, mental confusion)
Cerebral Vascular Accident with Residual Symptoms
Heart Failure, Atrial Fibrillation

Medications: Digoxin (Lanoxin^{R})
Haloperidol (Haldol^{R})
Papaverine HCl (Pavabid^{R})
Nitroglycerine (Nitrobid^{R})
Allbee with C^{R}
Ensure^{R}
Ibuprofen (Motrin^{R})
Keri Lotion^{R}

A. History

1. Medication: Only with reviewing entire record

2. Allergry/Adverse Drug Reactions: No allergies; drug reactions not mentioned.

3. Drug Abuse: Not present

B. Current Medications

1. Indications

--Digoxin--for heart failure and atrial fibrillation

--Haloperidol--probably for control of antagonistic behavior.

--Papaverine HCl and Nitroglycerine--are most likely being used to increase cerebral blood flow hoping to improve symptoms of organic brain syndrome. Most authorities feel that these drugs are ineffective for this purpose.

--Allbee with C^{R} (vitamins) and Ensure^{R}--are dietary supplements.

--Ibuprofen--no indication documented, but would assume some complaints of arthritis is the indication.

--Keri Lotion^{R}--no indication documented.

2. Contraindication: Haloperidol should be used with caution in persons with heart disease.

3. Drug Interactions: Possible additive hypotensive (blood pressure lowering) effects of haloperidol, papaverine HCl, and nitroglycerine.

4. Adverse Drug Reactions: None documented.

5. Dosage: The dosage of digoxin is on the high side for a person of this age (birth date, 12-8-1898). The dosage appears to be acceptable based on clinical parameters, but a digoxin blood level would be indicated for confirmation.

6. Prescriber: Order signed monthly.

7. Review: All medication orders are rewritten monthly by the nurse and signed by the physician. Progress notes written by the physician are frequent, but the handwriting is so difficult to read that it is doubtful the notes can be decifered even by the author. The nurses admit to having difficulties and express gratitude that the physician usually also tells them what he has written.

8. Goals: Need more specific definition

9. Medication Record: Present

C. Integration: Not documented.

Number: 3-34344 Location: Geriatrics Admitted: 2-18-77

Diagnoses: Schizophrenia, paranoid type
Hiatus hernia with esophageal reflux, esophagitis, and esophageal stricture
Benign Prostatic hypertophy
Right Inguinal Hernia
Atherosclerotic Cerebral Vascular Disease

Medications: Haloperidol (Haldol^{R})
Ensure^{R}

A. History

1. Medication: Only with reviewing entire record.

2. Allergy/Adverse Drug Reactions: No allergies; drug reactions not mentioned.

3. Drug Abuse: Not present

B. Current Medications

1. Indications

--Haloperidol--matches the diagnosis of schizophrenia.
--Ensure^{R}--is a dietary supplement.

2. Contraindications: Haloperidol has some, but not strong, anticholinergic effects which could aggravate the hiatus hernia, the esophagus problems, and the benign prostatic hypertrophy. Haloperidol probably has less of these effects than other antipsychotics, but still must be used with caution.

3. Drug Interactions: None apparent

4. Adverse Drug Reactions: None documented.

5. Dosage: Accpetable

6. Prescriber: Orders signed monthly

7. Review: All medication orders are rewritten monthly by the nurse and signed by the physician.

8. Goals: General goals stated.

9. Medication Record: Present

C. Integration: Not documented.

D. Comments: It seems highly unlikely that a person with a hiatus hernia and esophageal problems would not benefit form antacids. In fact, it is surprising that he is not already receiving antacids.

Number: 5-29888 Location: Geriatrics Admitted: 6-28-68

Diagnosis: Nonpsychotic Organic Brain Syndrome Secondary to Arteriosclerosis
TB, inactive
History of Phlebitis
Heart Failure
Epilepsy

Medications: Furosemide (Lasix^{R})
Digoxin (Lanoxin^{R})
Allbee with C^{R}
Thioridazine (Mellaril^{R})
Isoxsuprine HCl (Vasodilan^{R})

A. History

1. Medication: Only with reviewing the entire record.

2. Allergy/Adverse Drug Reactions: Not present

3. Drug Abuse: Not present

B. Current Medications

1. Indications

--Furosemide and digoxin--for heart failure

--Allbee with C^{R}--as a vitamin supplement

--Thioridazine--indication not documented

--Isoxsuprine HCl--probably intended to increase cerebral blood flow hoping to improve the symptoms of organic brain syndrome. Most authorities doubt the efficacy of this drug for this use.

2. Contraindication: Thioridazine has a potential to produce disturbances of the heart's rhythm, especially in the presence of pre-existing heart disease. Most other antipsychotics have less of a propensity for these effects than does thioridazine and therefore would have been a better choice, if indeed an antipsychotic is indicated.

3. Drug Interactions: There is a slight potential for additive hypotensive (blood pressure lowering) effects between Isoxsuprine HCl and Thioridazine. Furosemide potentiates the effects of digoxin by depleting myocardial, and total body, potassium. This effect is being monitored with monthly serum potassium determinations.

4. Adverse Drug Reactions: Digoxin toxicity in mid-December, 1977, as evidenced by bradycardia, confusion and disorientation and could have been anticipated because of decreased renal function as evidenced by elevated blood urea nitrogen and serum creatinine.

Number: 5499 Location: Geriatrics Admitted: 11-28-73

Diagnoses: Nonpsychotic Organic Brain Syndrome Secondary to Cerebral Arteriosclerosis
Allergy of unknown etiology
Diffuse, generalized osteoporosis of left knee
Seizure, unknown etiology

Medications: Phenobarbital
Papaverine HCl (Pavabid^{R})
Kenalog Cream^{R}
Dulcolax^{R} Suppositories

A. History

1. Medication: Only with reviewing the entire record.

2. Allergy/Adverse Drug Reaction: Possibly phenytoin (Dilantin^{R}), but the actual reaction and circumstances are not described.

3. Drug Abuse: Not present.

B. Current Medications

1. Indications

--Phenobarbital--for seizure disorder.

--Papaverine HCl--probably intend to increase cerebral blood flow hoping to improve the symptoms of organic brain syndrome. Most authorities believe papaverine is ineffective for this purpose.

--Kenalog^{R} Cream--probably for the allergy of unknown etiology.

--Dulcolax^{R} Suppositories--for constipation. Most authorities would prefer a bulk forming laxative, eg., metamucil and/or a stool softener, eg., dioctyl sodium sulfosuccinate, especially in a geriatric patient.

2. Contraindications: None apparent

3. Drug Interactions: None apparent

4. Adverse Drug Reactions: None documented

5. Dosage: Acceptable

6. Prescriber: Orders signed monthly.

7. Review: All medication orders rewritten monthly by the nurse and signed by the physician.

8. Goals: General goals stated

C. Integration: Not documented

The dosage of digoxin was decreased on 12-20-77 with apparent resolution of symptoms. A digoxin blood level at that time would have been helpful in establishing the correct dosage level, but was not done.

5. Dosage: Digoxin dosage initially too high (See Adverse Drug Reactions)

6. Prescriber: Orders signed monthly.

7. Review: All medications are rewritten monthly by the nurse and signed by the physician.

8. Goals: General goals stated.

C. Integration: Not documented.

D. Comments: From 2-21-78 to 2-28-78 he received 30 mg of Phenobarbital three times daily, but no order for this drug could be found on the chart. He has been on Phenobarbital in the past for epilepsy, but this was discontinued on 9-28-77.

Number: C 35768 Location: Geriatrics Admitted: 3-1-74

Diagnoses: Psychotic Organic Brain Syndrome associated with Senile Brain Disease
Seizure Disorder
Heart Failure with pulmonary edima

Medications: Phenytoin Na (Dilantin^{R})
Mycitracin^{R} Ointment

A. History

1. Medication: Only with reviewing entire record

2. Allergy/Adverse Drug Reactions: Not present

3. Drug Abuse: Not present

B. Current Medications

1. Indications

--Phenytoin Na--for seizure disorder. Mycitracin apparently for some process on left hip, most likely a bedsore.

2. Contraindication: None apparent

3. Drug Interactions: None apparent

4. Adverse Drug Reaction: Phenytoin toxicity may have contributed to an episode of heart failure with pulmonary edema on 2-8-78.

5. Dosage: Phenytoin was once too high but has been adjusted downward. The increase in phenytoin was apparently stimulated by a low serum phenytoin level (5.3 mcg/ml on 11-4-77) and a single documentated seizure on 1-19-78. This level is somewhat misleading since the serum albumin concentration at that time was also slightly low (2.9 Gm/dl on 1-3-78). The albumin concentration determines the precentage of drug not bound to plasma proteins. This unbound drug is the active drug. Nevertheless a dosage increment was probably not indicated unless further seizures occurred. On 2-8-78 phenytoin was discontinued, presumably because of toxicity, and on 2-14-78 was reinstituted at the same dosage as before the dosage increment. No seizures have been documented since.

6. Prescriber: Orders signed monthly.

7. Review: All medication orders are rewritten by the nurse monthly and signed by the physician.

8. Goals: General goals stated.

C. Integration: Not documented.

APPENDIX F

Accepted Professional Standards in Patient Care - Treatment

Accepted Professional Standards
In Patient Care and Treatment

by Dr. Jan Wollersheim

Licenses in psychology are generic and are not given in particular specialty areas. Rather, the licensee receives a letter from the Board of Psychologists designating his specialty area and this specialty area is also listed on the official lists of licensed psychologists which is published annually by the Montana Department of Professional and Occupational Licensing.

The problem described should be of concern to the individual psychologist because, when one obtains a license, he is bound by the licensing law which requires adherence to the ethical standards which specify that psychologists are to practice within their own specialty area. It should be stressed that this issue is not so much an issue for the hospital because under the present psychology licensing laws licensure requirements do not apply to State agencies or institutions. However, if a formal complaint is filed with the Montana Board of Psychologists, and if an investigation reveals that a psychologist is clearly practicing outside his area of competency, there exists grounds for revocation of the license.

There are several courses of action open to this individual. He may confine his work to those of a developmental psychologist in contrast to those of a practicing clinical psychologist. This alternative, however, may be unrealistic in terms of the psychological needs of the children on the unit. Another alternative, and perhaps the best one, would be that the psychologist officially enter a retraining program in order to change areas of specialization. Such a program is outlined in the March, 1976 APA Monitor, an official publication of the American Psychological Association. Should this course of action not be possible at the present time, a minimum requirement in order to comply with accepted standards of practice in psychology would be for the resident psychologist to be supervised by a licensed clinical psychologist who would be responsible for all of his clinical work. Such a supervisory relationship would allow the program psychologist to work in those activities deemed appropriate and, if these activities are clinical in nature, they would be supervised by a licensed clinical psychologist who would assume responsibility for them.

Clearly, the hiring staff at Warm Springs State Hospital should not be reprimanded for such a situation because there has been a considerable amount of confusion both nationally and state-wide regarding what qualifications constitute adequate training in various specialty areas in psychology. In the past year, both national and state rules and regulations have become much more clear cut. In hiring psychologists, the staff at Warm Springs State Hospital should feel free to seek out consultation regarding what constitutes adequate qualifications in this area from people knowledgeable about current professional practices. The Montana Board of Psychologists would be most happy to help any hiring agency evaluate the adequacy of a candidate's qualifications for the practice of clinical psychology. Agencies must be careful in the hiring of psychologists because all psychologists are entitled to be licensees. Experimental psychologists sometimes obtain licenses such that they can engage in consultation activities in their area of specialty. However, State agencies and institutions in the field of health care are most often interested in employing psychologists who are specialized in clinical work involving patient assessment and treatment. It is important then, in hiring practices, that they hire a licensed psychologist whose specialty area is designated as clinical psychology.

The unit director reported that he has received permission from the administration to hire a second psychologist for the children's program and that he will be trying to recruit a licensed psychologist whose specialty is clinical psychology. Such a psychologist would appear to fill the needs of the children of the program and might also be helpful in supervising the present developmental psychologist. The unit director was under the assumption that, according to licensing standards, a psychologist could be supervised by a psychiatrist or another psychologist. Rules and regulations were checked by this consultant, and a psychologist who is not licensed in the area of clinical psychology and who desires to do work in such an area must be supervised by a licensed psychologist whose specialty area is in clinical psychology.

APPENDIX G

VITAS

Dr. William Docktor, Clinical Pharmacist
Missoula, Montana

Dr. Frank Seitz, Clinical Psychologist
Bozeman, Montana

Dr. Jan Wollersheim, Clinical Psychologist
Missoula, Montana

RESUMÉ

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Education:

1.	Pharm. D.	University of Michigan	August, 1977
2.	B.S. Pharmacy	North Dakota State University	May, 1974

Professional Organizations:

1. American Society of Hospital Pharmacists
2. Montana Society of Hospital Pharmacists
3. American Association of Colleges of Pharmacy

Professional Licensure:

1. North Dakota
2. Indiana

Employment:

1. Assistant Professor of Clinical Pharmacy
   University of Montana, Missoula, Montana 59812
   September 12, 1977, to present

   a. Developing and teaching of Pharmacy 539 (Therapeutics, 5 hours), Pharmacy 507 (Introduction to Clinical Pharmacy, 3 hours), and Pharmacy 508 (Topics in Pharmacy Practice, 2 hours). All of the above courses are required for graduation and all are team-taught by myself and one other faculty member.
   b. Developing, administrating, and supervising Pharmacy 594 (Externship and Clinical Practicum, 15 hours). This is also a required course and involves practical experience for students in hospital and community distribution of drugs and direct patient and direct physician contact with the students.
   c. Developing and providing drug information services, eventually to the entire state of Montana.
   d. Developing clinical experience opportunities in local hospitals for student experience during externship(Pharmacy 594).
   e. Aid in developing progressive pharmacy service programs in local hospitals.
   f. Provide clinical pharmacy services in local hospitals.

g. Help hospital and community pharmacists who participate in Pharmacy 594 to develop themselves as professionals.
h. Participate as a member of the continuing education committee of the School of Pharmacy to develop programs to meet the needs of Montana's Pharmacists.
i. Act as chairman of the School of Pharmacy's library committee.
j. Act as advisor for one-half of the fifth year pharmacy class.

2. Associate in Clinical Pharmacy
Washington State University, Pullman, Washington
October 1, 1975 to June 1, 1976

This was a half-time faculty appointment combined with a residency in clinical pharmacy. All teaching and residency experiences were obtained in Deaconess Hospital, Sacred Heart Medical Center, and Family Medicine Spokane, all located in Spokane, Washington.

a. Teaching activities involved fifth-year pharmacy students during their practical experience course: formal lectures, formal and informal conferences, rounds, role model.
b. Provide clinical pharmacy services.
c. Provide nursing inservice education.
d. Provide formal conferences for medical interns and residents, other pharmacists, pharmacy students, and physicians.

3. Pharmacist
Osco Drug Inc. Elkhart, IN and Grand Forks, ND
June, 1974 to September, 1975

Retail pharmacy including dispensing, servicing a nursing home and Over-the-Counter consultation.

November 9, 1977

FRANK C. SEITZ, PH.D.

LICENSED CLINICAL PSYCHOLOGIST

DIPLOMATE IN CLINICAL PSYCHOLOGY - AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY

MEDICAL ARTS CENTER 300 NORTH WILLSON BOZEMAN, MONTANA 59715 PHONE (406) 586-2945

PERSONAL:

Born:	Oakland, California, September 13, 1942
Married:	Eva G. Spain, December 28, 1964
Children:	Two daughters

EDUCATION:

Undergraduate:	University of California, Davis Campus (National Science Foundation Seminar in Biology), Summer, 1960
	Catholic University of America, Washington, D.C. 1962-63
	Carroll College, 1960-62; 1963-64; B.A. Helena, Montana
Graduate:	M.A. in Psychology, University of Portland, 1964-66
	Ph.D. in Clinical Psychology, University of Colorado, 1966-1969.

PROFESSIONAL CREDENTIALS:

Diplomate in Clinical Psychology - American Board of Professional Psychology, Diploma Number 2872, 9/1/75

Licensed Clinical Psychologist - State of Montana - License Number 12, 4/23/71 to present

National Register of Health Service Providers in Psychology - Certificate Number 10991, 7/7/75 to present

HONORS AND AWARDS:

Basselin Foundation Scholarship, 1962-63

Carroll College Honor Scholarship, 1960-62; 63-64

Graduated from Carroll College, Maxima cum Laude, 1964

Delta Epsilon Sigma Academic Honor Society, 1964 (Initiation)

Pi Kappa Delta Forensic Honorary, 1960 (Initiation)

Woodrow Wilson Fellowship, Rhodes Scholarship, and Danforth Scholarship candidate from Carroll College, 1964.

Who's Who in American Colleges and Universities, 1964.

Division of Vocational Rehabilitation Fellowship, 1965-66.

United States Public Health Service Fellowship, 1966-67.

University of Colorado Graduate Scholarship, 1968-69.

American Men and Women of Science, 1972 to present.

Who's Who in the West, 1976, 1977

PROFESSIONAL EXPERIENCE:

1965 and 1966 (summers): Psychologist I & II at the Helena Mental Hygiene Clinic, Helena, Montana.

1964-65: Teaching assistant for General Psychology at the University of Portland.

1965 (fall semester): Practicum placement at the Oregon state retardation facility at Salem, Oregon.

1966 (spring semester): Practicum placement at Goodwill Industries, rehabilitation division, Portland, Oregon.

1966-67: Research assistant to Dr. Victor Raimy studying controlling techniques used by college students in group situations.

1967 to 1969: Clinical Psychology Intern, Veterans Administration Hospital, Denver, Colorado.

January to August, 1969: Clinical Psychology Intern, Mental Hygiene Clinic, Veterans Administration Hospital, Denver, Colorado.

1968 (Fall quarter): Psychology instructor, St. Thomas, Denver, Colorado.

October, 1968 to August, 1969: Psychologist at the Center for Student Life Programs and Studies (Counseling Center), University of Colorado, Boulder, Colorado.

August, 1969 to August, 1970:

Clinical and Counseling Staff Psychologist, Veterans Administration Hospital, Denver, Colorado.

Supervised psychology interns in individual and group psychotherapy, and in psychodiagnostic techniques.

Clinical Psychology consultant for the Organ Transplant Unit.

Counseling and Rehabilitation Psychology liaison with various Federal, State and local rehabilitation agencies.

Clinical Psychology consultant for psychiatric resident training, and for inservice training programs for psychiatric aids and nurses.

September, 1971 to August, 1972:

Kellogg Extension Education Project - Evaluation Team Co-director.

August, 1970 to present - Montana State University

Clinical Psychologist at the Student Health Service, Montana State University, Bozeman, Montana.

- Individual Psychotherapy and Marriage Counseling
- Psychological Consultation with University Staff.

Associate Professor in the Psychology Department

- September, 1970 to August, 1975 - Conducted classes in Theories of Psychotherapy, Abnormal Psychology, Psychology of Adjustment, Individual

Mental Measurements, Personality Assessment, Introduction to Counseling.

- June, 1975 to Present - Chairman of the System of Human Behavior Course (WAMI First Year Medical School Program)

August, 1971 to present - Private Practice in Clinical Psychology

- Individual Psychotherapy and Marriage Counseling
- Psychodiagnostic Testing and Evaluation
- Psychological Consultation

(1) Clinical Psychology Consultant to the Montana General Agency for Northwestern Mutual Life Insurance Company.

(2) Clinical Psychology Consultant to the Catholic Diocese of Helena Permanent Diaconate Program.

THESES AND DISSERTATION:

Seitz, F.C. The relative effectiveness of positive and negative reinforcement in verbal conditioning. Unpublished M.A. thesis, University of Portland, 1966.

Seitz, F.C. The Psychotherapeutic treatment of neurotic depression: A self-confrontation approach. Unpublished specialty paper, University of Colorado, 1968.

Seitz, F.C. A psychotherapeutic approach to depression: The immediate impact of video-tape confrontation and/or psychotherapeutic discussion on the self-concept and behavior of neurotically depressed patients. Unpublished doctoral dissertation, University of Colorado, 1969.

PAPERS PRESENTED AT PROFESSIONAL MEETINGS:

Seitz, F.C. The relative effectiveness of reward and punishment in verbal conditioning. Paper presented to the Colorado Psychological Association, Fall, 1966.

Anderson, D.O., & Seitz, F.C. Rorschach signs and homosexuality. Paper presented to the Colorado Psychological Association, Spring, 1969.

Seitz, F.C. Audio-video tape and psychotherapy: Research, training, and service. Presentation as part of a panel for Colorado Psychological Association, Spring, 1970.

Seitz, F.C. Psychological concomitants of heart and transplant surgery. Presentation as part of a panel for Psychiatric Grand Rounds, University of Colorado Medical School, April 27, 1970.

Seitz, F.C. Neurotic depression: A self-concept approach. Paper presented to the Rocky Mountain Psychological Association, Salt Lake City, May, 1970.

Seitz, F.C. The behavior modification techniques used for treating depression: A survey and analysis. Paper presented to the Rocky Mountain Psychological Association, Salt Lake City, May, 1970.

Seitz, F.C. The behavior modification techniques used for treating depression: A survey and analysis. Paper presented to the Rocky Mountain Psychological Association, Salt Lake City, May 1970.

Seitz, F.C. The impact of videotape confrontation and discussion on neurotically depressed patients. Paper presented to the Rocky Mountain Psychological Association, Salt Lake City, May, 1970.

Andersen, D.O., Seitz, F.C., & Braucht, G.N. Rorschach signs of homosexuality: A comparative analysis. Paper presented to the Rocky Mountain Psychological Association, Salt Lake City, May, 1970.

Seitz, F.C. Behavior modification of depression. Paper presented to the American Psychological Association, Washington, D.C., September, 1971.

Seitz, F.C. A second look at behavior modification treatment of depression. Paper presented to the Montana Psychological Association, Missoula, April, 1973.

Seitz, F.C. Problems of individual mental testing of children. Presentation as part of a panel at the Montana Psychological Association, Missoula, April, 1973.

Seitz, F.C., & Schneider, J.R. The application of behavior modification techniques to the treatment of depression. Paper presented at the Banff International Conference on Behavior Modification, Banff, Canada March 25, 1975.

Seitz, F.C. Detection of brain dysfunction. Chairman of panel at the Montana Psychological Association, Missoula, April, 1976.

Seitz, F.C. Interviewing problems in collecting subjective vs. objective data on illnesses. Presentation at the Montana State University Workshop on Epidemiological Approaches for Health Workers, February, 1977.

Seitz, F.C. Update of the psychologist's role in disability determination. Chairman of panel at the Montana Psychological Association, Bozeman, April, 1977.

Seitz, F.C. Clinical Psychology and third party payment. Chairman of panel at the Montana Psychological Association, Bozeman, April, 1977.

Seitz, F.C. & Prunty, W.S. Psychopathology and rehabilitation. Workshop presented to the State of Montana rehabilitation counselors, Bozeman, April, 1977.

PROFESSIONAL REFERENCE PUBLICATIONS:

Andersen, D. O., & Seitz, F. C. Rorschach diagnosis of homosexuality: Schafer's content analysis. Journal of Projective Techniques, 1969, 33 (5), 406-408.

Seitz, F. C. Science -- A creative search. Psychology, 1969, 6 (3), 41-42.

Seitz, F. C. Five psychological measures of neurotic depression: A correlation study. Journal of Clinical Psychology, 1970. 24 (4), 504-505.

Seitz, F. C. Neurotic depression: A self-concept description. Psychology, 1970, 7 (2), 2-5.

Seitz, F. C. A behavior modification approach to depression: A case study. Psychology, 1971, 8 (1), 58-63.

Seitz, F. C. Ammons' Quick Test as a measure of adult intelligence in a psychiatric sample. Psychological Reports, 1971, 29, 356-358.

Seitz, F. C. Behavior modification techniques for treating depression. Psychotherapy: Theory, Research and Practice, 1971, 8 (2), 181-184.

Seitz, F. C. Detection of learning difficulties in first grade: Preliminary analysis of the Johnson-Kenny Screening Readiness Test. Psychological Reports, 1973, 33, 219-225.

Seitz, F. C., Andersen, D. O., & Braucht, G. N. A comparative analysis of Rorschach signs of homosexuality. Psychological Reports, 1974, 35, 1163-1169.

Seitz, F. C., Willis, M. P., & Johnson, R. C. The J-K Screening Readiness Test as a measure of first grade learning difficulties: A cross-validation study. Perceptual & Motor Skills, 1976, 42, 803-809.

OTHER PROFESSIONAL PUBLICATIONS:

The effectiveness of reward and/or punishment delivered under two conditions of verbal conditioning. Newsletter for Research in Psychology, 1968, 10 (3), 7.

Perceptual defense revisited. Newsletter for Research in Psychology, 1968, 10 (4), 1-2.

A behavior modification approach to depression: A case study. Newsletter for Research in Psychology, 1969, 11 (1), 10-12.

Use of implosive therapy in treating a recurrent dream. Newsletter for Research in Psychology, 1969, 11 (4), 2.

The Kellogg Extension Education Project: A First Year Evaluation of Selected Leadership Variables (with W.R. Lassey, Kris Jones, & Scottie Giebink). Mimeograph Paper, September, 1972.

PROFESSIONAL ORGANIZATIONS AND ACTIVITIES:

American Psychological Association - member
Rocky Mountain Psychological Association - member (1969-1976)

Montana Psychological Association
- Member (1970 to present)
- Board of Directors (1971-76; 1977 to present)
- Insurance Chairman (1976 to present)
- MPA Liaison to Montana Social & Rehabilitative Services
- President-Elect (1977-78)

State of Montana Developmental Disabilities Council - (1975-77)
State of Montana Eugenics Board (1973 to present)

Montana Association of Churches - Legislative Coalition:
Task Force on Family Courts (1977)
18th Judicial Court Juvenile Advisory Board - (1970-72)

Gallatin Council Drug Treatment & Rehabilitation Advisory Committee
Bozeman Help Center Advisory Board
Gallatin County Mental Health Program - Provider

Psychological Reports - Special reader for the editorial board (1973 to present)

REFERENCES -- Provided on request

PROFESSIONAL RESUME

(Updated October, 1977)

VITA

Name:	Janet P. Wollersheim
Born:	July 24, 1936, Anaconda, Montana
Marital Status:	Married to Daniel J. Smith (two children)
Home Address:	3100 Park Street, Missoula, Montana, 59801
Home Phone:	(406) 543-6946
Office Phone:	(406) 243-2581 or (406) 243-4521

EDUCATION

1963-1968	University of Illinois, Urbana-Champaign, Illinois
1958-1960	St. Louis University, St. Louis, Missouri
1954-1958	Gonzaga University, Spokane, Washington
1950-1954	Anaconda Central High School, Anaconda, Montana
1942-1950	Parochial Schools, Anaconda, Montana

DEGREES - (With Majors and Minors)

Ph.D. - 1968	University of Illinois, Urbana, Illinois Majors: Clinical Psychology and Developmental Psychology (Child) Minor: Education (Child Development)
M.A. (research) - 1960	St. Louis University, St. Louis, Missouri Major: Psychology
A.B. - 1958	Gonzaga University, Spokane, Washington Major: Psychology Minors: Education, Philosophy

EXPERIENCE

Sept. 1977-Present	Professor of Psychology, University of Montana, Missoula, Montana. (Teaching at graduate and undergraduate levels in adult and child clinical psychology; research; supervision of graduate student research and clinical work.)
Sept.-Dec.-1977	Psychological Consultant for State of Montana Office of the Legislative Audit. (Evaluation of efficiency and effectiveness of school psychology services in the Montana public schools.)
Dec. 1973-Present	Mental Health Consultant to Trapper Creek Job Corps, Darby, Montana. (Consultation to staff and training of staff regarding psychological adjustment of corpsmen; doing some work with individuals and groups of corpsmen with adjustment problems.)
Spring 1971-Present	Psychological Consultant to Montana State Prison, Deer Lodge, Montana. (Presentation of training programs concerning managing and rehabilitating prisoners to correction officers.)

Sept. 1974-Aug. 1977	Associate Professor of Psychology, University of Montana, Missoula, Montana. (Teaching at graduate and undergraduate levels in adult and child clinical psychology; research; supervision of graduate student research and clinical work.)
Oct. 1971-March 1974	Psychological Consultant to Western Montana Child Development Center, Missoula, Montana. (Consultation to staff and to problem children and their families and to school systems regarding problem children; supervison of clinical work of graduate students.)
Sept. 1971-June 1974	Assistant Professor of Psychology, University of Montana, Missoula, Montana. (Teaching at graduate and undergraduate levels in adult and child clinical psychology; research; supervision of graduate student research and clinical work.)
Sept. 1971-Dec. 1971	Psychological Consultant to Warm Springs State Hospital, Warm Springs, Montana. (Primary responsibility for designing and implementing three new mileu treatment-research projects.)
Feb.-Sept. 1971	Clinical Psychologist, Warm Springs State Hospital. (Assessment and treatment of individual patients; in-service training for hospital personnel; initiation of and responsibility for three new treatment-research projects.) (Accepted this position as temporary position while on leave from University of Missouri.)
1970-Feb. 1971	In a group private practice with three other clinical psychologists; Psychology Associates of Columbia, Columbia, Missouri.
1969-Feb. 1971	Assistant Professor of Psychology, University of Missouri. (In clinical psychology teaching on graduate and undergraduate levels in areas of adult and children's behavior disorders and psychological treatment; conducting psychotherapy outcome research.)
	Assistant Director of Testing and Counseling Center in charge of Clinical Services. (Administration of clinical services which handles clients with emotional problems; directing training for clinical psychology graduate students; supervision of Ph.D. students in clinical and counseling psychology, consultant to counselors on cases with severe emotional problems; individual and group psychotherapy.)
1968-1969	Clinical Psychologist - University of Missouri Mental Health Clinic and Visiting Lecturer, Department of Psychology, University of Missouri. (Evaluation and treatment of clients with severe emotional problems; supervision of psychologists in training; teaching adult behavior disorders.)
1967-1968	Supervising three clinical graduate students in their conducting of group psychotherapy with college girls using both traditional and behavior therapy techniques; personally conducting three such psychotherapy groups weekly.
1967-1968	Internship in Clinical Psychology at Veterans Administration Hospital, Danville, Illinois. (Psychodiagnosis and individual and group psychotherapy with psychotic, neurotic and brain damaged patients; training in neuropsychological diagnosis using the Halstead-Reitan batteries; planning treatment programs with ward personnel and members of other professions.)
1964-1967	Student Psychologist at University of Illinois Psychological Clinic. (Psychodiagnosis and treatment of adult and children out-patients.)

Summer, 1966	Research Associate, Institute of Research for Exceptional Children, University of Illinois. (Psychological evaluation of culturally deprived children; conducting research with these children.)
1965-1966	Teaching assistant and then Instructor in psychodiagnostic course. (Lecturing and supervising the clinical diagnostic work of graduate students, University of Illinois.)
Summer, 1965	Psychologist for Champaign, Illinois, Head Start Program for culturally deprived children.
1964-1965	Teaching assistant in Psychodiagnostic courses, University of Illinois. (Supervising students in psychodiagnostic courses in the areas of intelligence, personality and social and emotional adjustment.)
Summer, 1963	Research Associate and Psychological Consultant for Jane Addams Graduate School of Social Work, University of Illinois. (Research and evaluating interviewing skills of social work students.)
1961-1963	Qualified Psychological Examiner for Champaign Public Schools. (Psychological evaluation of normal and exceptional children; supervising diagnostic work of interns in school psychology; consultation with teachers and parents; research.)
1959-1961	Internship in School Psychology, Champaign Public Schools, Champaign, Illinois. (Diagnostic evaluation of normal and exceptional children; consultation with teachers and parents; research.)
1958-1959	Combined Fellowship and Teaching Assistantship, St. Louis University. (Assistant in courses on learning theory and psychological testing.)
1956-1959	Counselor in Girls' Dormitory.

(During seven years at the University of Montana have been active on a number of departmental, interdepartmental, and University committees, including chairperson of the department's Research Committee for three years, and chairperson of the department's Personnel Committee from 1975 to present.)

HONORS

1978 -	To be listed in Who's Who in the West.
1977 -	Listed in Who's Who of American Women.
1975 -	Awarded a merit raise to begin 1975-76 school year at the University of Montana.
1972 -	Sigma Xi, National Science Honorary, University of Montana.
1971 -	Listed in Dictionary of International Biography.
1969 -	Listed in American Men and Women of Science.
1967 -	University of Illinois Fellow - awarded by University of Illinois Graduate College.

Straight A average at the University of Illinois while obtaining Ph.D.

U.S. Public Health Fellowship in Clinical Psychology for two years at the University of Illinois.

Graduate fellowship in psychology at St. Louis University.

Continuous academic scholarships throughout undergraduate years - Elks Competitive Award, Crown-Zellerbach Scholarship, Gonzaga University Competitive Scholarship, etc.

Graduate from college as class salutorian and graduated summa cum laude.

Many awards in high school and college for acting, debate, oratory and academic competition.

SPECIAL QUALIFICATIONS

National Register of Health Service Providers in Psychology - qualified as a health service provider for listing in this register.
Licensed Psychologist - State of Montana (specialty areas in clinical, developmental and school psychology).
Certified Psychologist - State of Missouri.
Registered Teacher in State of Illinois for grades Kindergarten through 14.
Registered School Psychologist - Qualified Psychological Examiner - State of Illinois.
Registered Psychologist - State of Illinois.

SCHOLARLY AND RESEARCH ACTIVITIES

Publications

Chapters in Books

Wollersheim, J. P. Specific behavioral techniques. In E. E. Abramson (Ed.), Behavioral Programs for the Treatment of Obesity. Springer Publishing Company, in press.

Wollersheim, J. P. Training for the applied psychologist in a University Psychological Services Center. In G. F. Farwell, N. R. Gamsky, and P. Mathieu-Coughlam (Eds.), The Counselor's Handbook. New York: Intext Educational Publishers, 1974. Pp. 95-108 (with King, P. T.)

Wollersheim, J. P. Behavior therapy with children: A broad overview. In S. G. Sapir and A. C. Nitzburg (Eds.), Children with Learning Problems. New York: Brunner-Mazel, 1974. Pp. 625-647. Also appears in S. Chess and A. Thomas (Eds.), Annual Progress in Child Psychiatry and Child Development: 1968. New York: Brunner-Mazel, 1968. Pp. 356-378 (with Werry, J. S.)

Wollersheim, J. P. Effectiveness of group therapy. In N. Kiell (Ed.), Psychological Approaches to Obesity. Springfield, Illinois: Charles C. Thomas, 1973. Pp. 245-264.

Wollersheim, J. P. The efficacy of two organizational plans for underachieving intellectually gifted children. In M. Kornrich (Ed.), Underachievement. Springfield, Ill.: Charles C. Thomas, 1964. Pp. 594-609 (with Karnes, M. B., McCoy, G. F., Zehrbach, R. R., Clarizio, H. F., Costin, L. & Stanley, L. S.)

Monograph

Wollersheim, J. P. A comparative study of two preschool programs for culturally disadvantaged children: A highly structured and a traditional program. Urbana, Ill.: Institute of Research on Exceptional Children, August, 1966 (with Karnes, M. B., Stoneburner, R. L. and Hodgins, A. S.)

Journal Articles

Wollersheim, J. P. A cognitive-behavioral approach to the treatment of psychopathy. Psychotherapy: Theory, Research and Practice, in press (with Templeman, T. L.)

Wollersheim, J. P. Scientist-practitioner activities among psychologists of behavioral and non-behavioral orientations. Professional Psychology, in press (with Bornstein, P. H.)

Wollersheim, J. P. Follow-up of behavioral group therapy for obesity. Behavior Therapy, to appear in Vol. 8, No. 5, Nov. 1977.

Wollersheim, J. P. WISC patterns and the characteristics of reading disabled children. Perceptual and Motor Skills, in press (with Johnson, D. A.)

Wollersheim, J. P. Book review of Mahoney, M. J., Scientist as subject: The psychological imperative. Ballinger Publishing Co.: Cambridge, Mass., 1976. To appear in Behavior Therapy, in press.

Wollersheim, J. P. A comparison of the test performance of average and below average readers on the McCarthy Scales of Children's Abilities. Journal of Reading Behavior, in press (with Johnson, D. A.)

Wollersheim, J. P. Testing the efficacy of relaxation in a treatment package for obesity. JSAS Catalogue of Selected Documents in Psychology, 1977, 7, 76 (Ms. No. 1531).

Wollersheim, J. P. Beyond psychoanalysis but not quite an overview. Book review of Usdin, Gene (Ed.), Overview of the Psychotherapies. New York: Brunner-Mazel, 1975. Contemporary Psychology, 1976, 21, 369-370. (This book is the annual volume in continuing education published by the American College of Psychiatry.)

Wollersheim, J. P. The effect of labeling of special education students on the perceptions of contact versus noncontact normal peers. The Journal of Special Education, 1976, 10, 187-198 (with Cook, J. W.)

Wollersheim, J. P. Obesity: Behavioral treatment manuals. JSAS Catalog of Selected Documents in Psychology, 1975, 5, 237 (Ms. No. 934)

Wollersheim, J. P. Assessment of suicide potential via interview methods. Psychotherapy: Theory, Research and Practice, 1974, 11, 222-225.

Wollersheim, J. P. Cognitive desensitization. Journal of Contemporary Psychotherapy, 1974, 6, 146-153.

Wollersheim, J. P. Bewail the Vail, or Love is not enough. American Psychologist, 1974, 29, 717-718.

Wollersheim, J. P. Hospital treatment innovations via in-service training projects. Psychological Reports, 1973, 33, 58.

Wollersheim, J. P. The effectiveness of group therapy based upon learning principles in the treatment of overweight women. Journal of Abnormal Psychology, 1970, 76, 462-474.

Wollersheim, J. P. An evaluation of two preschool programs for disadvantaged children: A traditional and a highly structured preschool. Exceptional Children, 1968, 34, 667-676. (See erratum notice in Exceptional Children, 1968, 35, 95. (with Karnes, M. B., Stonebrunner, R. L., Hodgins, A. S., Teska, J. A.)

Wollersheim, J. P. Behavior therapy with children. Journal of the American Academy of Child Psychiatry, 1967, VI, 346-370 (with Werry, J. S.)

Wollersheim, J. P. An intensive differential diagnosis of partially-seeing children to determine the implications for education. Exceptional Children, 1963, 30, 17-25 (with Karnes, M. B.)

Wollersheim, J. P. A pilot study comparing the block system and intermittent system of scheduling speech correction cases in the public schools. Illinois Speech and Hearing Association Newsletter, 1967, IV, 4-5, 8 (with Weaver, J. B.)

Wollersheim, J. P. The efficacy of two organizational plans for underachieving intellectually gifted children. Exceptional Children, 1963, 29, 438-446 (with Karnes, M. B., McCoy, G. F., Zehrbach, R. R., Clarizio, H. F., Costin, L., & Stanley, L. S.)

Wollersheim, J. P. Factors associated with underachievement and overachievement in intellectually gifted children. Exceptional Children, 1961, 28, 167-175 (with Karnes, M. B., McCoy, G. F., Zehrbach, R. R., Clarizio, H. F., Costin, L. & Stanley, L. S.)

Papers

Wollersheim, J. P. The effect of therapy rationales upon the perception of clinical depression. Paper presented at the Rocky Mountain Psychological Association Annual Conference, May 11-14, 1977, Albuquerque, New Mexico (with Bugge, I.)

Wollersheim, J. P. Is clinical psychology worthwhile? Only if we adhere to uniqueness in training. Presentation at Rocky Mountain Psychological Association Annual Conference, Phoenix, Ariz., May 12-15, 1976.

Wollersheim, J. P. Behavior modification training and the Scientist-Practitioner Model. Paper was presented at the Association for Advancement of Behavior Therapy Annual Convention, San Francisco, California, Dec. 12-14, 1975 (with Bornstein, P. H.)

Wollersheim, J. P. Follow-up study of behavioral group therapy in the treatment of obesity. Paper presented at Rocky Mountain Psychological Association Annual Convention, Salt Lake City, Utah, May 7-10, 1975.

Wollersheim, J. P. Beyond ethical standards: A descriptive analysis of the perceived legal liabilities of psychologists. Paper presented at Rocky Mountain Psychological Association Annual Convention, Salt Lake City, Utah, May 7-10, 1975 (with Wahlberg, J. L.)

Wollersheim, J. P. Behavioral treatment of obesity: Comparison of two behavior therapy groups. Paper presented at the Rocky Mountain Psychological Association Annual Convention, Denver, Colorado, May 8-11, 1974.

Wollersheim, J. P. Internal-external locus of control and impression management among prison inmates. Paper presented at Rocky Mountain Psychological Association Annual Convention, Denver, Colorado, May 8-11, 1974 (with Woolston, W. D.)

Wollersheim, J. P. The effect of labeling of special education students on the perceptions of contact versus no-contact normal peers. Paper presented at Rocky Mountain Psychological Association Annual Convention, Denver, Colorado, May 8-11, 1974 (with Cook, J. W.)

Wollersheim, J. P. Assessment of suicide potential via interview methods. Paper presented at Montana Psychological Association Annual Conference, Missoula, Montana, April 27-28, 1973.

Wollersheim, J. P. Obesity: Clarification and suggestions for treatment. Paper presented at Rocky Mountain Psychological Association Annual Convention, Las Vegas, Nevada, May 8-11, 1973.

Wollersheim, J. P. Cognitive desensitization. Paper presented at Rocky Mountain Psychological Association Annual Convention, Albuquerqu New Mexico, May 9-13, 1972.

Wollersheim, J. P. Treatment innovations via in-service training projects. Paper presented at Montana Psychological Association Annual Converence, Billings, Montana, April 14-15, 1972.

Wollersheim, J. P. Techniques of supervision. Keynote address at National Vocational Rehabilitation and Social Welfare Supervisors Workshop, University of Missouri, Columbia, Missouri, April 23-25, 1969.

Wollersheim, J. P. Creative ability in gifted children. Paper presented at Illinois Council for Exceptional Children Annual Conference, Chicago, Illinois, Spring, 1962.

Wollersheim, J. P. The relationship between creative ability and over- and under-achievement among gifted children. Paper presented at American Psychological Association Annual Convention, St. Louis, Missouri, September, 1961.

(Also very active in chairing and being a committee member on M.A. theses and Ph.D. dissertations.)

Research Interests

Major research interests are in the areas of treatment outcome research, the role of cognitive variables in assessment and treatment and child-clinical psychology.

SYMPOSIA, COLLOQUIA AND WORKSHOPS

May, 1977	Invited research colloquium on "The Role of Cognitive Variables in Assessment and Behavior Change." Psychology Department, University of Miami, Coral Gables, Florida.
May 13, 1977	Presentation of workshop on "Cognitive-Behavioral Approaches to the Treatment of Depression and Suicide," at the Rocky Mountain Psychological Association Annual Conference, Albuquerque, New Mexico (with Walters, H.A.)
April 1977	Invited panel member on "Licensing Issues." Montana Psychological Association Annual Conference, Bozeman, Montana.
July & Nov. - 1977	Presentation of two two-day workshops to two different groups of Roman Catholic Nuns on "Adjustment Problems and Personal Growth as a Religious." Helena, Montana.
July & Sept. - 1977	Presentation of two workshops to Butte, Montana's Community Co-ordinated Child Care Agency on "Fostering Intellectual, Social and Emotional Growth in Young Children." Butte, Montana.
Nov. 4 & 5 - 1976	Presentation of two-day continuing education workshop on "Depression" for the Montana Academy of Professional Psychologists, Fairmont Hot Springs, Gregson, Montana (with Walters, H. A.)
Nov. 1976	Presentation to newly-ordained priests of the Helena Diocese of Western Montana on "The Role of the Priest in Counseling."
June 1976	Presentation of 2-day workshop on "Behavior Modification" and "Group Counseling" for Job Corps staff members in the Western National Region. Butte, Montana, June 29-30, 1976.

May & Oct. - 1976	Presented two in-service training programs for the Anaconda, Montana, Head Start personnel on "The Management of Problem Children." Anaconda, Montana.
Oct. 1975	Invited participant on two panels concerning topics in school psychology. Conference of Montana Association of School Psychologists, Great Falls, Montana, Oct. 22-23, 1975.
Summer 1974	Presentation of three 2-day workshops throughout Montana on "Managing and Treating Depression" for professional social workers. Workshops sponsored by the University of Montana Department of Social Work and the State of Montana Department of Social Rehabilitation Services. Missoula, Butte, and Great Falls, Montana.
Sept. 1973	Invited panel member on Montana Committee for the Humanities Conference on "Insanity and the Law." Chico Hot Springs, Montana.
April 1973	Invited symposium participant on "Problems in individual mental testing of children." Montana Psychological Association Annual Conference, Missoula, Montana, April 27-28, 1973.
March 1973	Invited colloquium on "Program Evaluation and the Clinical Psychologist as Scientist-Practitioner." Psychology Department, University of Nebraska, Lincoln, Nebraska.
April 1973	Invited member of panel on "Master's Degree Program in Psychology," Montana Psychological Association Annual Conference, Billings, Montana.
Feb. 1971	Invited colloquium on "The Psychological Treatment of Obesity" at University of Pennsylvania, Philadelphia.
Winter & Spring 1968	Invited colloquia on "The Psychological Treatment of Obesity" at Universities of Houston, Calgary, Missouri, and Gonzaga University.
Spring 1968	Invited colloquium on "Behavioral Counseling with Children" at University of Illinois, Urbana, Illinois.

TEACHING INTERESTS

Behavior Disorders (adult and children)
Psychological Treatment (especially cognitive-behavioral approaches)
Child Clinical Psychology
Psychological Assessment
Clinical Practicum
Depression and Suicide

SPECIAL RECOGNITION

Oct. 1975- Oct. 1978	Appointed by Governor Thomas L. Judge of Montana as one of three psychologists to serve on the Board of Psychologists of the State of Montana. (The Board administers the law regarding the licensing of psychologists for private practice and regulates the private practice of psychology in the State of Montana; 1975-76, Secretary of the Board; 1976-77, Vice-Chairman of the Board; 1977-78, Chairman of the Board.)
Fall 1976- Present	Special consultant reviewer for Journal of Consulting and Clinical Psychology for obesity and therapy manuscripts.
Fall 1976- Present	Invited consultant reviewer for obesity and therapy manuscripts for Behavior Therapy.

1971-Present	Serve as an occasional consultant reviewer for Psychological Reports and Perceptual and Motor Skills.
Fall 1976	Invited participant on American Psychological Association internship site evaluation team for internship accreditation.
Summer 1976 & Summer 1975	Invited visiting professor at the International Graduate School in Leysin and Lugano, Switzerland. (Taught graduate courses in Advanced Children's Behavior Disorders and Cognitive-Behavioral Approaches to Treatment.)
1972-Present	Professional consultant to Milton Bradley Publishing Co., for GOAL Project (a curriculum for preschool children based upon the Illinois Test of Psycholinguistic Abilities) developed by Dr. Merle B. Karnes, Institute of Research for Exceptional Children, University of Illinois, Urbana.
1975-1977	Appointed to American Psychological Association Committee for awarding "The Distinguished Professional Award in Child Clinical Psychology" for 1977 to a psychologist having made outstanding contributions in the area.
Jan. 1973	Invited member of 14-person professional national review team solicited by U.S. Office of Education to evaluate psychological services in Montana funded by U.S. Department of Health, Education & Welfare through the Model Cities Programs.
Summer 1973	Invited consultant reviewer for treatment outcome studies for Journal of Applied Behavior Analysis, Vol. 70.
1971-Summer 1973	Special consultant editor to Journal of Abnormal Psychology on obesity studies and therapy outcome research.
1970-1971	Served on Clinical Projects Research Review Committee of National Institute of Mental Health. (Invited as a site visitor and project proposal reviewer for psychotherapy outcome research on obesity.)

PROFESSIONAL SERVICES

1976-Present	Member of School Psychology Co-ordinating Committee and member of Ethics Committee, Montana Psychological Association.
1975-1976	Member of Executive Committee of the Montana Psychological Association-Member-at-Large.
Spring 1973-Present	Member of Missoula, Montana, Head Start Advisory Health Board.
Oct. 1972-Present	Member of professional advisory board of Missoula, Montana, Chapter of Parents Without Partners.
Oct. 1971-Present	Back-up Counselor, Missoula, Montana, Crisis Center.
Mar. 1972-Mar. 1973	Professional Member of Board of Directors, Missoula, Montana, Crisis Center.

(Many speeches as a professional psychologist to community groups such as PTA and TOPS (Take Off Pounds Sensibly) weight reducing groups, agencies, Parents Without Partners, appearances on local television programs, etc.)

(Several invited lectures on selected topics in psychology in Psychology Department and other departments at the University of Montana.)

MEMBERSHIP IN PROFESSIONAL OR SCIENTIFIC SOCIETIES

American Psychological Association - also belong to Divisions 12 (Clinical Psychology), 7 (Developmental Psychology), 25 (Experimental Analysis of Behavior), and 29 (Psychotherapy)
Montana Psychological Association
Rocky Mountain Psychological Association
Council for Exceptional Children (local, state and national membership)
Montana Academy of Professional Psychology
Illinois Psychological Association
Psi Chi
Gamma Phi Epsilon - National College Honorary
Missouri Psychological Association
Missouri Academy of Science - University of Missouri Honorary

PROFESSIONAL REFERENCES

Dr. James A. Walsh, Professor of Psychology, Department of Psychology, University of Montana, Missoula, Montana, 59812.
Dr. John G. Watkins, Professor of Psychology and Director of Clinical Training, Department of Psychology, University of Montana, Missoula, Montana, 59812.
Dr. Herman A. Walters, Professor of Psychology and Director of Clinical Psychology Center, Department of Psychology, University of Montana, Missoula, Montana, 59812.
Dr. Richard A. Solberg, Dean, College of Arts and Sciences, University of Montana, Missoula, Montana, 59812.
Dr. Philip H. Bornstein, Associate Professor of Psychology, Department of Psychology, University of Montana, Missoula, Montana, 59812.
Dr. Donald R. Peterson, Dean of Professional School of Psychology, Rutgers University, New Brunswick, New Jersey.
Dr. Gordon L. Paul, Psychology Department, University of Illinois, Urbana, Illinois.
Dr. John S. Werry, Professor and Head, Department of Psychiatry, School of Medicine, University of Auckland, Auckland, New Zealand.
Dr. Leonard P. Ullmann, Psychology Department, University of Hawaii, Honolulu, Hawaii.
Dr. Merle B. Karnes, Department of Education, Institute of Research for Exceptional Children, University of Illinois, Urbana, Illinois.
Dr. Armelda Prast, Director of Internship Training, VA Hospital, Danville, Illinois.
Dr. Alvin Landfield, Psychology Department, University of Nebraska, Lincoln, Nebraska.